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ABSTRACT

Presented is the final report of the Family Center Project, a program designed to increase the number of reported cases of suspected child abuse and neglect and increase the services for abused and neglected children and their families in Adams County, Colorado. Three chapters which address the goal of increasing child abuse referrals focus on public awareness and professional education, a school referral program, and the crisis intake process. Eight chapters concern the following treatment topics: the role of the nurse on a child abuse team, the multidisciplinary review team, treatment of abusive adults, lay therapy, treatment of abused and neglected children, the crisis nursery, therapeutic nursery care, the therapeutic day care. Three chapters focus on project dissemination and research aspects. (CL)

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FAMILY CENTER

"A Community Based Approach to the Problems of Abusive Families"

edited by Margaret A. Nicholson
Carol J. Schneider

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"Copr." Margaret A. Nicholson, 1977

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PREFACE

TO: M. A. Nicholson, Project Director
The Rest of the Staff

Dear Ms. Nicholson:

I would like to take this opportunity to recognize the outstanding programs which the Family Learning Center developed over the past three years. Our community has been fortunate to have services such as the comprehensive ones provided by the Family Center for abused children and their families.

It is indeed unfortunate that the Family Center is closing, as it has been a distinguished model for effective and meaningful intervention and protective services.

C. Henry Kempe, M.D.
Professor of Pediatrics and Microbiology
Director of National Center for Prevention and Treatment of Child Abuse and Neglect

ACKNOWLEDGEMENT

This manuscript is dedicated to the children, families, and community of Adams County. Special acknowledgement is given to K. Deborah Landsman, Betty Bianchi, Elaine Okerson, David Rest, Lolly Otto, and Betty Maze for their aid in data analysis in the project's research effort.

INTRODUCTION

Margaret A. Nicholson

The Family Center Project was jointly funded as a part of a national demonstration effort in child abuse and neglect program services.* The three goals of the project effort were to:

1) increase the number of reported cases of suspected child abuse and neglect;
2) increase the amount and type of treatment services for abused and neglected children and their families; and
3) utilize and dissiminate the findings of the project's program.

Many agencies in Adams County were concerned about the limited resources for abused and neglected children and their families. Representatives of the Adams County Department of Scoial Services, Mental Health Center, Juvenile Court, Juvenile Probation, School District, and the Tri-County Health Department formed a committee to address these concerns. As a result of their work, the project's goals and program concepts were created in the initial grant proposal which was submitted to the Office of Child Development and funded in May, 1974. The project began its operation with the employment of the director in August, 1974.

These three goals were to be attained through the specific programs of the project. In the first goal area the School Referral Program was designed to increase reporting through the public schools. Crisis Response Intake services were designed to encourage reporting by providing immediate response to referrals. One part of the Public Awareness and Professional Education Program area was designed to raise the interest level and to educate the lay and professional citizens to their responsibility in reporting cases of suspected child abuse. Another program which was related to all of the goals was the Role of a Nurse on a Child Abuse Team. Through the utilization of a medical person on the project staff, doctors, hospitals, and other nurses became more willing to report suspected cases as well. These specific programs are discussed in more depth in the following chapters.

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*The Family Center Project was jointly funded by the U.S. Department of HEW, Office of Child Development and Social and Rehabilitation Services, Grant No. 90-C-73.

The second goal of the project was to increase the amount and type of treatment services in Adams County. The program area objectives related to attainment of this goal are the following:

Treatment of Adults
Treatment of Children
Crisis Nursery Program
Therapeutic Day Care
Therapeutic Foster Care
Lay Therapy
Role of the Nurse on a Child Abuse Team
Multidisciplinary Review Team

These treatment programs were implemented by project staff in cooperation with other agencies. Each of these treatment areas is discussed in more detail as separate chapters in this text. Additional treatment resources have been developed in the county and project staff have provided training and technical assistance to their development and implementation.

The utilization and dissemination of the project's program and results was the third major goal of the Family Center. Program areas related to this goal are Public Awareness and Professional Education, the Research on the Effectiveness of Treatment in the Family Center Project, the Role of a Nurse on a Child Abuse Team, and the Transition of the Project's Programs to the Adams County Department of Social Services. These specific programs are explained in chapters titled as above in this test. The utilization and dissemination of this project will be a continuing process through publications, national conferences, and consultation with other programs provided by project staff.

This final report and its availability is another example of the dissemination effort in reference to the Family Center Project. The following chapters identified the various program goals, objectives, implementation tasks, and outcome. The Family Center staff is anticipating that this information will be helpful and utilized by program planners and researchers working in the field of child abuse and neglect.

The Family Center Project was located in Adams County, Colorado. This county is located in the metropolitan area of Denver, and the geographic area is comprised of suburban and rural sections. The population of Adams County was projected at 214,800 by the Colorado State Planning Division as of 1975. One of the largest ethnic groups in the county is Chicanos, or Spanish surname families, estimated at 15 percent of the total population. Another large ethnic group is Italian families.

Within the county there are parts of 13 separate communities, each with its own law enforcement agency, and there are six major school districts. There are very few private human service agencies and the agencies mentioned above are primarily responsible for all service delivery to families in Adams County. In addition, there is one small agency, the J.F.K. Developmental Center, that serves a small number of children.

The Family Center Project continued to receive support from these agencies in the community. A separate chapter is offered in this text which identifies the specific assistance given on behalf of the abused child and his/her family. Another chapter identifies the efforts of the grantee agency, the Adams County Department of Social Services, and the planning for continuing the project's efforts in Adams County.

The Family Center Project began operating in August, 1974, and implemented the various programs in the first project year. The project's programs were either transitioned into the grantee agency or ended in April or May, 1977. The staff prepared this report in June and July, and the final editing and preparation of the report were completed in August, 1977.

The staff sincerely hopes this material is helpful for planning and implementing specific programs and is a contribution to the state of the art of the prevention and treatment of child abuse.

PUBLIC AWARENESS AND PROFESSIONAL EDUCATION

Mark Grassman, Mary Maroon
Robert Mc Donald, Margaret Nicholson
and
Susan Pass

Introduction

As orginally conceived, this program component of the Family Center project was intended to coordinate efforts already taking place in the area of public awareness and professional education and to develop new resources. The major goals of this effort were to bring about an increase in the reporting of suspected and actual cases of child abuse; to enhance the general public's knowledge of the child abuse problem, and those resources available for its treatment and prevention; and to increase public support for the expansion of these resources.

There were two primary objectives through which these goals were to be accomplished: the establishment of a speakers bureau, and the dissemination of information. The speakers bureau was designed to coordinate those efforts already going on in the area of public awareness and education relating to the child abuse problem, and to recruit other people to join in their effort. The Family Center staff comprised the major part of the speaker's bureau. During the course of the project they responded to speaking requests from all sectors of the lay and professional community, and, over the life of the project, spoke to over one thousand people. Project staff were joined in this effort by interested professionals from other community agencies directly or indirectly involved with child protection.

Project staff and other professionals involved in the public awareness and education effort occasionally had interviews or articles printed in the local press, or appeared on local t.v. and radio. These publications and appearances enhanced the visibility of the Family Center project, and focused attention on its attempts to sensitize the community to the various issues involved in the child abuse problem. Letters from all around the country were received which requested information regarding the project's programs. Another part of this objective was to provide consultation and information to visitors to the project and provide training to other parts of the country.

Implementation

Educational Sector

Aside from numerous speaking engagements in the elementary and secondary schools in the community, which are described in detail in the School Referral Program, there were also attempts to inform other parts of the educational community regarding the child abuse problem. Various project staff and other members of the speaker's bureau were occasionally asked to make presentations on child abuse to classes of local colleges and universities. In most instances these were classes in degree programs of areas such as psychology, nursing, primary, secondary and special education, liberal arts, etc. Presentations were made at evening classes specifically being offered to adults by a local university in the area of parenting preparation. Some project staff were directly involved in the development and teaching of classes for persons in the field of education who wished to learn more about the child abuse problem. Several project staff were involved in teaching a class on lay therapy at a local university. As the public education effort increased, the number of requests also increased.

Lay Groups and Professional Groups

As part of the public awareness and professional education program, the project staff was involved in providing information regarding child abuse to different groups in the community. These groups basically were divided between lay groups and professional groups. Some of the lay groups that were provided information on child abuse were the League of Women Voters, foster parents associations, church groups, PTA's, American Legions, day care associations, Kiwanis, Jaycees, mothers groups, secretarial groups, Rotary groups, and neighborhood groups. The inservicing of these groups primarily focused on such issues as the child abuse reporting law, the definition of abuse, the extent of child abuse, the demographic information on the abusive parent and abused child, and the types of treatment available to the parents and children.

The second group trained were people who worked in service agencies or institutions and who might professionally come into contact with abusive parents and their children. This group included Mile High United Way, Catholic Community services, other county social services, hospitals, day care centers, public health centers, mental health cneters, American Indian Center, Human Services, Incorporated, John F. Kennedy Outreach, American Human Association, Metropolitan Child Protection Council, National Center Conference on Child Abuse and Neglect, URSA Training, Council for Exceptional Children, National Center for the Prevention and Treatment of Child Abuse and Neglect Annual Symposium, Colorado Head Masters, Cherry Creek Schools Annual Mental Health Conference, and the Tenth Annual

Emotional Crisis Workshop of University of Northern Colorado. Because many of these groups had direct contact with abusive families, the inservices focused on such issues as the legal mandate on reporting of suspected child abuse, the dynamics of abuse, the psychological profile of the abusive parent and abused child, the treatment process, initial interviews with abusive parents, and how other agencies could provide services to abusive families. Depending on the particular professional group, certain areas of abuse were emphasized.

With both the lay and professional groups the inservice training included use of films, slides, lectures and discussion.

Law Enforcement

The project offered an educational program about child abuse to all of the thirteen county law enforcement agencies, as well as to the state training academy for juvenile officers. The goal of this educational effort was to foster cooperation, communication, and understanding between law enforcement agencies and the county departments of social services. The staff emphasized this goal with law enforcement agencies because they realized that law enforcement personnel came in contact with families regularly and that they have been trained in the legal aspects of child abuse. They were also aware that, during the first year of the project, law enforcement agencies were the primary group expected to respond to child abuse reports. As a way of achieving this goal, project staff emphasized five main areas when addressing law enforcement personnel: 1) the dynamics of abuse, 2) the identification of abuse, 3) a clinical picture of the parents and the child, 4) the role of the protective services worker, and 5) the social worker's perception of the police officer's role. In explaining the dynamics of abuse and giving a clinical picture of the parents and the child, the project staff hoped to expose law enforcement personnel to the psychological information. By reviewing ways to identify an abused child, the staff intended to sensitize police officers to emotional as well as physical signs of abuse. They also facilitated discussion through the use of role playing and slides to help police officers understand their own feelings and emotions about child abuse. Finally, the staff wanted to initiate a mutual appreciation and understanding of job responsibilities by delineating the roles of the protective service worker and the police officer. In all of the training sessions, the project staff found it beneficial to involve the juvenile officer from the requesting agency in the presentation, because under those circumstances the trainees appeared more invested in the content of the presentation.

Methods Utilized in Public Awareness and Education Program

A basic format utilized by most members of the speaker's bureau in making presentations on child abuse to groups or classes involved the following:

1. Showing the film, Children in Peril, which was purchased for the use of the speaker's bureau by a local chapter of the Jaycees Organization. Much of this film was made locally, focusing on what was being done about the child abuse problem in the Denver metropolitan area. Slides relating to the physical diagnosis of child abuse were often used during in-services with the medical community.
2. The showing of the film was normally followed by an explanation of the Family Center project; the interdisciplinary effort at work in the community to deal with child abuse; clinical issues involved in the diagnosis and treatment of child abuse; local resources available to help abused children and abusive parents; the Colorado Children's

Code, etc. There might also be comment made about points highlighted in the film which had relevance to the local community. For example, the lay therapy program, Parents Anonymous, child protection teams, the role of the juvenile court, etc.

3. A discussion and a question and answer period usually followed.

For statistical information about presentations, refer to Table 1. Because of the length of the film (twenty-three minutes), or the nature of the occasion or group being addressed, the film was not always a part of the program. And even though it was often helpful to have a visual presentation which conveyed a vivid impression or raised questions in peoples' minds, it was sometimes desirable to have more time to devote to verbal presentation and group discussion. Regardless of the techniques employed, however, there were several key issues which speakers generally attempted to convey to all audiences. They were:

1. Dealing with the myths that child abuse is solely a problem of the poor, or of racial and minority groups; and the myth that child abuse is an isolated phenomenon specific to a small group of very disturbed or very ill people. Child abuse has a relationship to other more subtle characteristics such as an inability to show genuine affection, a lack of interpersonal problem-solving skills, or the acceptance of violence or extreme passive-aggressiveness as appropriate forms of relating or problem-solving.
2. Child abuse is often a generational or cyclical problem.
3. Child abuse is often related to inadequate preparation for marriage and parenthood, and to a lack of knowledge about child development.
4. The importance of having access to support systems when crises arise and parents fear losing control.

TABLE 1

PUBLIC AWARENESS AND EDUCATION

(September 1974 - April 1977)

Total Presentations	262	100%
Social Service Groups	34	13%
Educational Groups (Including Student Groups)	149	57%
Medical Groups	45	17%
Law Enforcement	7	3%
Other	27	10%
Total People Addressed	7240	
Average Length of Presentation	2 Hours	
Method of Presentation	Percent Used	
Film	40%	
Slides	6%	
Discussion, including questions and answers	100%	
Role Play	3%	
Handouts	96%	

5. The existence of treatment resources in the community to help families or individuals involved in the abuse problem.

Participation by Community Personnel

From the inception of the project, the staff intended to complement its own public awareness and professional education effort by utilizing other resources within the community. They decided to do this because they realized that their ultimate goal was to create programs that the community could carry forward after the project terminated. As the project became more visible within the community and the requests for speaking engagements became overwhelming, the project staff realized that there was also a practical reason for utilizing other community resources.

The project created a formal speaker's bureau wherein other professionals within the community working in child abuse offered their time to fulfill speaking engagements. These people represented the department of social services, the Tri-County Health Department, juvenile probation, the schools, law enforcement, and Parents Anonymous. In addition the district juvenile court judge and the assistant district attorney often spoke to various community groups at the request of the project staff.

Although the majority of presentations was made by Family Center staff, other community agencies were involved in 20 percent of the presentations made.

Community Organizing and Planning

The Family Center Project staff became involved with organizing for children's issues, and they were specially involved with issues related to abused and neglected children and their families Over the life of the project, the staff became involved with many advocate groups, advisory boards, and were consultants to other human service agencies.

One example of the groups that the project staff became involved with was the Metropolitan Child Protection Council. The project director was elected as a board member as well as the legislative committee chairperson. Through this advocate group, alliances were established between Legal Aid, Parents Anonymous, the social service departments, juvenile judges, attorneys, and the lay public. The legislative committee worked for seven months to create a statute to "terminate the parent-child legal relationship." Legislature sponsorship was obtained and a network of telephone and letter writing support was initiated which resulted in new legislation in the State of Colorado. The governor of the state signed the bill into law June 19, 1977.

The project staff became involved in other community efforts. The local health department was in jeopardy of losing funding due to cutbacks, and the project staff participated in a telegram and letter writing campaign. School districts sought project staff support in grant writing, school board presentations, and letter writing campaigns.

Parents Anonymous was a group that the staff supported and assisted from its beginning in Adams County. Their efforts were supported through group sponsorship, through public speaking and training, and by board membership. Additionally, project staff made numerous referrals of parents to Parents Anonymous groups.

Philosophically, the project director believed that child advocacy was broader than issues related only to the incidents of abuse and neglect. Thus, any local effort related to children was of concern and resulted in action from the project. Issues related to day care funding, Parents Anonymous, handicapped children, funding cuts, and program changes were addressed by the director.

The project director viewed part of her role as an administrator in the child abuse field to assist in planning meetings and to provide consultation to other county social service departments. Over the life of the project, the director worked with the Colorado Congressional Delegation, the State Advisory Board for Training and Technical Assistance, the Metropolitan Child Protection Council, the State Task Force on Protective Services, the Title XX Advisory Board on Training Grants, the Adams County Multidisciplinary Review Team, and the Regional Council for Parents Anonymous.

Organizing on behalf of children is an essential part of providing a program for abused children and their families. Children usually are not able to speak for themselves and their parents are not often heard by the policymakers and funding resources. In addition, the lack of a significant power base in most social service agencies does not allow for a significant amount of influence or power to secure the necessary funds for needed programs. Thus, the organizing effort must involve many people from a cross-section of society in order to facilitate enhancing child welfare programs.

Increased Number of Referrals

As the number of presentations being made by the speaker's bureau to various church, civic, business, and education groups in the community increased, the number of child abuse referrals increased (Refer to Table 2). This development created several problems. The first and most serious one was that the increased number of referrals put an additional burden on the child protective service system which was already overworked and understaffed.

The complications of this development are apparent in several ways. The increased number of referrals and larger caseloads has had a negative impact on the morale of the staff involved in protective services. A sense of

TABLE 2

REFERRAL SOURCE

ADAMS COUNTY CHILD ABUSE INTAKE

(November 1974 - October 1976)

	Nov. 1974 - Oct. 1975		Nov. 1975 - Oct. 1976	
	#	%	#	%
Total Intakes	414	100	575	100
Self-Referrals	14	3	38	7
Private Source	118	29	166	29
Relative	51		52	
Day Care Mothers	15		9	
Neighbor/Unrelated Person	52		105	
Schools	54	13	117	20
Police	32	8	53	9
Hospitals	37	9	72	12
Public/Private Social Welfare Agencies	157	38	129	22

*This report includes referral sources for all child abuse intakes completed by the Family Center and the Adams County Department of Social Services. These intakes resulted in an abuse, potential abuse, or not abuse case designation for children birth through 18 year.

being overwhelmed or of never being able to 'catch up' is present among many staff. Another frustration has been that staff feel that the quality of the service which is being offered has been compromised. The increased number of referrals has also made it more difficult to respond to situations as quickly as might be desired, especially in referrals of a less serious nature. Referrals of serious physical injury or alleged sexual abuse continue to receive immediate attention. Another result of the increased referrals has been that the protective service system is now less able to provide services to families when the referral pertains to an emotionally or psychologically abusive situation, or a situation of potential physical abuse. Because of the high case loads and restrictions on funding for more staff, the Adams County Department of Social Services has had to develop a policy where only cases of documented actual abuse or cases in which the abusive client requests treatment will be accepted as treatment cases. The department will continue to assess every referral it receives.

Since a heightened awareness of the law, the extent of the abuse problem, who to call, and what help is available has occurred among the general public, the problem of limited staff with increased referrals exists. It is quite understandable that the public education effort might receive some of the frustration and anger being generated by the problems within the system. If this blaming of educational efforts increases as the burdens on the system continued to grow, there could be a policy decision to stop educating the lay and professional public. In fact, the Colorado Joint Budget Committee of the State Assembly has suggested that prevention and public education efforts be halted. This is a case of placing blame for the high caseloads solely on the public education effort, and therefore, a gross misinterpretation of the true nature of the problem.

The effort to make the public aware of the full nature of the child abuse problem as well as where to report suspected or actual cases of abuse needs to continue. The fact that the system designated to deal with this problem is being seriously weakened by an excessive workload needs to be addressed at a legislative and societal level, where problems are given priority and funds allocated.

A Problem Particular to Rural Areas

During the course of the project some lay and professional education was given in rural areas fifty miles or more from the Family Center. It was found that the child abuse problem exists in these communities as well as in more populated areas. People in the rural areas were just as anxious to learn more about the dynamics of the problem, to learn what can be done of a preventive nature, and where help can be obtained if the problem already exists. This last point presented a problem since these communities were far removed from those tax-supported resources available in the county to help families and individuals. The need was identified, therefore, to develop mental health, social service, and public health resources more readily accessible to rural areas in order to provide help to those families already experiencing abusive problems.

Outcome

Part of the goal of the public awareness program was the dissemination of the project model and specific programs. The project staff believe they achieved this goal. During the three years more than 7000 people were personally trained in the prevention and treatment of child abuse. In addition, papers were presented at national and local conferences, and consultation was given to programs throughout the country as well as a significant amount to local and state social services programs. Project staff were involved in providing consultation and planning to groups working on the development of other programs. One staff member was very helpful in sharing her experience and knowledge of the therapeutic day care program. She consulted with two other community agencies interested in establishing similar programs as well as another agency which was writing a training grant.

The lay therapy coordinators provided consultation to several county departments of social services, out-of-state visitors to the project, and presentations of the lay therapy program at national conferences. The lay therapy coordinators also taught a course at the University of Colorado Denver Center on lay therapy.

The Crisis Nursery staff often provided consultation to visitors to the project on the operation, goals, objectives, routine, and costs of a crisis nursery. The houseparent participation in these meetings provided invaluable wisdom gained from experience for agencies beginning similiar programs.

A nurse working in social service departments or in community based child abuse programs was a new aspect of programming in Colorado. The Family Center nurse established her role as a nurse and consulted with other agencies attempting to develop similiar positions. The nurse was also helpful in training student and community health nurses in the prevention and treatment of child abuse.

The School Referral Program was very successful in establishing reporting of child abuse and neglect procedures for school districts. As other school district personnel and community people became aware of the program, the project received many requests for consultation, copies of the Adams County procedures, and the literature that was used in training school personnel. Requests for information regarding this program were received from all around the country. The project director wrote a chapter for a child abuse book to be published by the Council for Exceptional Children.

The staff believes that as the project's research analysis is made available, many agencies will seek to learn more about the treatment effectiveness.

Consultation is an important follow-up to any model effort, and it is anticipated that the Office of Child Development will utilize the programs and the research results to assist in policy decisions as well as in their consultation with agencies.

Additionally, child abuse specialists from other counties visited the project during their visits to the National Center for the Prevention and Treatment of Child Abuse and Neglect located in Denver.

Training

Over time, the project staff became aware of the importance to the process and effect of training to have an accurate perception of:

--Who was requesting the training?
--Why was it being requested?
--What was expected?
--What effect was anticipated?

When staff were adequately prepared regarding the above, they were much better able to utilize their knowledge and skill to train the participants.

Training of other social service department personnel was, at times, difficult, particularly when either the administrator or the middle management staff requested the training. Problems arose when everyone involved in the training was not clear about the "why" and "what was to be the result." The project staff learned over a period of time that it was essential to have the request approved through all of the administrative structure within the requesting agency. When this did occur, there appeared to be a greater investment in learning and utilizing the training.

In training public lay groups the staff became more aware of community attitudes regarding abused children and parents. Feelings such as denial, rage, empathy, over-protectiveness, etc., were expressed, and the staff trainers had to prepare themselves to be nonjudgmental and facilitate discussions to further explore feelings or to dispel myths that were expressed.

Results of this program area were difficult to assess. However, preliminary results indicate many Colorado County Departments of Social Services have started lay therapy programs, 38 public school districts have child abuse and neglect reporting procedures, 23 counties have child protection teams, some counties are beginning crisis nurseries, and many other results are anticipated. It is important to note that the staff does not assume that the efforts mentioned above were all as a direct result of the project. However, one of the effects of having a demonstration project can be the stimulus it provides to a particular field or community. Because of the wide publicity the project's efforts have received, it is believed the Family Center was such a stimulus.

SCHOOL REFERRAL PROGRAM

Ann Brown, Mark Grassman
Mary Maroon, Robert Mc Donald
Margaret Nicholson, Susan Pass
and
Vicki Van Dyke

Introduction

As the authors of the Family Center grant proposal conceived the concepts of the project, they identified the issue of schools reporting very few cases of child abuse and neglect. They were aware that many school age children were being abused, but reporting of these incidents was most often initiated by someone else in the community. Thus, the School Referral Program was designed as a component of the project.

One of the Adams County School Districts had established a reporting procedure to encourage reporting of suspected cases of child abuse. It was this model that the project used as a basis for further development of the School Referral Program.

The primary goal of this program was to increase reporting of suspected cases of child abuse and neglect in the Adams County Elementary Schools. In addition, the project staff sought to increase reporting by Headstart, Parochial Schools and day care personnel as well. Two objectives were used to achieve this goal. The first was the assignment of one Family Center staff to each of the six school districts, and through that liaison relationship, establishing a reporting procedure for each district. The second objective was to identify one school person in each elementary school as the "reporting" person for suspected cases of child abuse and neglect.

A secondary goal was to enhance school personnel's knowledge and understanding of abused and neglected children and their families. An objective for meeting that goal was to provide inservice training to all elementary school district personnel in the identification and reporting of abused and neglected children.

In the first year of the project's efforts, reporting procedures were designed, approved, and implemented. In the 1974-75 school year there was a 300 percent increase in reporting from the schools. In the same academic year 98 percentage of all principals were trained and 78 of all elementary school personnel were trained. Refer to Appendix 1.

Designing the Intervention and Implementation in the Schools

Six Family Center staff members were assigned to districts with whom they were familiar. Given this familiarity, the individual liaison was able to identify school personnel who were knowledgeable and committed to the problems of abused children. These prior relationships were extremely helpful in assisting the staff to become aware of the district's decision-making processes and prevailing attitudes. Through discussions with these school staff, an initial strategy was planned to intervene with each district.

The staff's strategy was to meet with the superintendent in each of the districts. Written and verbal requests for meetings with the superintendent or his designee were quickly honored. The purpose of these meetings was to review the child abuse reporting act; to explain the proposed role of the Family Center liaison person; and to acquire support from the superintendent to meet with the school board to propose a policy statement regarding child abuse and neglect.

As a result of these meetings strategies were planned. In some districts, it was not necessary to meet with the school boards because the superintendent was able to establish an administrative procedure for effectively reporting cases of suspected child abuse or neglect. Many superintendents assigned the responsiblility of working with the Family Center liaison to the Director of Special Services or Pupil Personnel. In districts where board policy was established, the process was very expedient and effective. The Family Center liaison, in cooperation with school administrative personnel, designed a school board policy statement including:

1. the Colorado Child Reporting Statute,
2. an expectation that all school personnel would comply with the statute, and
3. that the school district's goal was to protect and help abused and neglected children and families.

These policy statements were readily passed by the boards of education.

Following the establishment of board policy the Family Center liaison and the school personnel designed child abuse and neglect reporting procedures. These procedures were very clear and simple and usually were only one page in length. The following is an example of the usual process identified in the procedure.

1. The teacher observes a child that he or she suspects to have been abused or neglected.
2. The teacher discusses the child with either the school nurse or social worker. (Each school building has a designated person responsible for reporting child abuse and neglect.)
3. The school nurse talks to the child and examines the child. The school nurses are specially trained by the Family Center nurse to identify and describe injuries.
4. The reporting person telephones the referral to the Family

Center or social service department. All known history on the family is given, as well as a description of the injury and any available explanation.

5. The reporting person completes a state child abuse reporting form and notifies the principal immediately.

After the reporting form is completed, the social service agency assumes responsibility for investigating the referral and works closely with the school in the pursuit of protecting the child and offering services to the family. To accomplish this, the Family Center or social service social worker completes the following steps:

1. The social worker telephones the state central registry to determine if the family and/or child had been reported prior to this incident. Additionally, the worker checks to make sure the case is not an open or closed case at the department of social services with a social worker already assigned.
2. The social worker goes to the school to discuss the referral with the reporting person, with the teacher, and often with the child.
3. The parents are telephoned and the social worker makes an appointment to meet with them regarding the injury to the child. In cases where the parents are not available, the child is detained at school or the worker and child meet the parents at their home at the end of the school day.
4. The social worker provides a complete evaluation on the family. The results of this evaluation are directly related to whether the child is placed out of the home.
5. The social worker provides his or her assessment, evaluation, and recommendation to the Multidisciplinary Review Team. This is an interagency team in Adams

County, which reviews all child abuse and neglect referrals on a weekly basis. The team provides either additional recommendations or suggestions to the worker. On occasion, the school reporting person attends these meetings to assist in the development of a case plan.

6. The social worker sends the school reporting person a letter stating the case plan and follow-up so that the school is aware of the plan.

Each of the six school district's policies were slightly different from each other, but the basic content of the reporting procedure was similiar. Refer to Appendix 2.

After the procedures were designed, the Family Center liaison met with all of the principals either in one large group or in many smaller groups. The directors of special services were helpful in setting up meetings and they, too, were a part of the discussion. The procedures and policies were presented and principals had the opportunity to discuss their feelings and concern about reporting suspected cases of child abuse and neglect.

During one of these meetings a principal identified his concerns regarding law suits and fear of parental anger. The Family Center liaison explained the "immunity from prosecution" article of the statute and shared a copy of the law with all the principals. The fear that parents would be too angry to cooperate with the schools was partially dispelled by advising the principals that the Family Center or social services would not be identifying to the parents the source of the referral. Although a parent's assuming the school made the report might occur, the risks are more severe in not reporting a case. Another suggestion that was helpful in overcoming resistance that was often accepted was that the nurses or social workers become the building reporting person. It was explained that the nurses and social workers have been trained to deal with angry and hostile people,and that the principals could use their own staff's expertise to work with the parents.

After much discussion and an extensive training session with the principals, they committed themselves to use the reporting procedure and to arrange inservice training sessions with their faculty groups. The teachers and other schools personnel were trained by Family Center staff in all of the elementary buildings in the six school districts. Each school building had an identified reporting person(s) who would report the case. During this training, intake social workers from the social service department who assessed neglect referrals also participated.

The Family Center nurse was very helpful in this process in training school nurses how to interview a child about his/her injuries, how to assess the injury in relation to the explanation, and how to train staff in properly documenting the injuries.

The policy, procedure, training, and results was accomplished through a great amount of leadership, commitment, and cooperation from the schools. The School Referral Program also effected the development of additional cooperative efforts between the project and the school districts.

Related Program Areas

The project social workers assigned as liaisons to the districts came to be considered as resource persons. Their input extended beyond the initial working relationship between the Family Center project and the school districts. This resulted from the liaisons' exposure to district staff and administration.

Classroom Speaking Engagements

As the liaison social workers came to be identified as community consultants on child abuse, various district staff began approaching the liaisons with requests to speak to classes or special groups within the district. Over the three years of the project's existence, the number of speaking requests from schools became so numerous that the liaisons occasionally had to help each other meet the overflow of speaking requests from their various districts. Each year the number of schools and classes in which child abuse was being studied by students for the first time increased. The social workers attempted to effect an increased awareness of and sensitivity to child abuse as a pervasive social problem and as an issue appropriately studied within the context of public education.

The emphasis in these classroom speaking engagements was not to present the child abuse problem as an isolated phenomenon. It was necessary to discuss the problem within a specific context, attempts were also made to place child abuse into a larger framework; one which had an impact on everyone's life, not just on those individuals and familes known to the courts and child welfare systems. Child abuse was placed within a context of issues with which the students readily related: interpersonal problem-solving abilities; communication skills; violence as a way of relating and problem solving; corporal punishment as a form of discipline; the common lack of preparedness for marriage and parenthood; and family discord.

Students at all levels; elementary, junior and senior high schools, demonstrated an interest in the child abuse problem. Project staff were frequently asked to assist individual students or small groups of students who had chosen to do papers dealing with child abuse.

The junior and senior high school classes which most frequently requested speakers on child abuse were: psychology, sociology, social problems, child development, personal living, and bachelors' survival classes. The format generally used in making these presentations was an initial talk on the etiology, nature, and dimensions of the problem, along with some discussion of approaches to treatment and prevention. This was normally to be followed by a period of discussion, and question and answer.

With many of the junior high school classes, the technique of role playing was often found to be the most effective way of dealing with the various issues involved in the child abuse problem. In the role playing, vignettes depicting family arguments, the punishment and abuse of a child, abuse intake evaluations, courtroom scenes, etc. were acted out by the students with the liaison's direction. These situations graphically brought the substantive issues involved in the child abuse problem to the students' attention. They also frequently provoked a quality of discussion which surprised even the students' teachers. The sessions in which the liaison was present were normally followed by several other classes in subsequent days in which the teachers followed up on discussions generated in the initial session and the role playing sequence. One junior high school class went to witness a hearing in the county juvenile court as a part of the time spent on the child abuse issue.

Younger students, 14 years and under, generally demonstrated a greater willingness and ability to deal with the more emotive aspects of the child abuse problem. They appeared to feel more free and less inhibited in discussing their feelings about the psychological, interpersonal and societal subtleties of child abuse. They were less interested in hearing the social worker recount incidents involving children who had been seriously injured; social workers who had been attacked by angry parents; or police officers who had to arrest a violent parent. These topics were, however, frequently focused on by older teenagers or even by adults during speaking engagements, the relative freedom to explore the issue fully observed in the younger children prompted further study by teachers in at least one school district. They introduced elementary and junior high school students to a structured examination of child abuse within a framework of affective education. The intent was to develop a part of a curriculum which could be incorporated in any social science or related course. This idea was pursued and has been implemented on a limited basis in several schools.

The liaison in one school district worked with a sixth grade teacher to develop and implement an experimental curriculum on child abuse involving six sessions over a six-week period. It was an attempt to sensitize students to a host of issues related to family life, parenting and child abuse. The basic methods employed were informal discussion and role playing. The students responded very well to the subject matter and gave evidence of having previously thought a great deal about the above stated issues, but they had not had a forum in which to discuss them. Some teachers and administrators are continuing their efforts to incorporate this subject matter as a permanent part of the school's course of study.

This preventative approach to the child abuse problem provided students the opportunity of exploring issues vital to their emotional and psychological development during the early years of their education. It was anticipated they would be better prepared for the challenges of adulthood, marriage and parenthood. A more thoroughly prepared and better educated student on such issues might be less likely to develop abusive tendencies. This hypothesis was partially based on the findings of the project that a lack of knowledge regarding child development issues, poor interpersonal problem solving abilities, low self-esteem and unsatisfying interpersonal relationships were often highly correlated with the existence of abusive tendencies. An educational approach addressing these issues might yield a reduced incidence of child abuse in future generations or at least knowledge of where to get help if the problem develops.

Project staff were also occasionally asked to consult with school district personnel in various capacities. In some instances they were interested in data that was collected during the project. They utilized this information in developing grant proposals for programs designed to help special needs children. School personnel periodically consulted with project staff around the implementation of specific programs involving children who were disadvantaged due to some form of abuse or neglect.

In several districts where the increasing numbers of pregnant or married students prompted the development of alternative programs for them, project staff became integrally involved with these programs on a regular basis.

Westminster OOPS Group

In School District 50, two project staff became involved in an alternative program for students who were either pregnant or who already had children, the "OOPS Program", Optional Opportunities for Pregnant Students. They met with the students on a weekly basis during the course of the entire school year. While these sessions were designed as an intergral part of the students' curriculum, the format was purposely left unstructured and open ended. The intent was to provide a forum within which a variety of issues could be addressed, and student needs met. Essentially, these classes had a dual focus: informational and educational, and therapeutic.

While the subject matter discussed frequently alternated between the two above stated major focuses, there were general topic areas which were specific to each one. In the informational/educational area these were:

1. Child development issues: What constitutes normal and abnormal behavior, what are appropriate expectations for children at their various stages of development.
2. Approaches to parenting and disciplining children: Is physical punishment necessary, what other approaches are available and realistic, the need for structure and consistency with children.
3. Child abuse: What constitutes abuse, why do parents abuse, how can abusiveness be stopped, who are likely to be abusive parents.
4. Interpersonal problem solving and communication skills: Is it possible to problem solve without abusiveness and violence, the correlation between satisfying relationships and effective communication.

The issues addressed in the area comprising a therapeutic focus were:

1. Frustrations and fears of being parents: Where did their own childhood go; how can they meet the needs of their children if their needs are not being met by anyone; the awesomeness of the responsibility and the restriction on their freedom which it poses; the fear of hurting a child in a moment of depression or frustration.
2. Relinquishment and abortion: What are the feelings involved; what will family and friends say; might I regret the decision later; what are the ethical considerations for me.
3. Feelings about being maried: Why did I marry, is he involved in the raising of the child; Do I feel 'trapped', and if so,

what should I do, how has marriage affected my relationship with close friends, peers.

4. Sexuality: Attitudes toward sexuality after pregnancy and bearing a child; feelings of "having gotten caught" while others go free; feelings of having been used; negative body image; negative attitudes toward sexuality in general.
5. Anger toward men: Lack of any positive male role model in their past lives; skepticism about there being any caring men in the world; feelings of having been victimized by men; possible history of sexual abuse by father or stepfather.
6. Attitudes toward parents and natural families: No one understands or cares; pregnancy or marriage as a way out; unhappy or chaotic family background, what are the chances that I will be able to have a happy family.
7. Stereotyping and being stereotyped: Feelings about the label of the "pregnant teenager" or "single parent;" are all men bad; are all authority figures unjust.

These issues were often raised by the students. During the sessions, the project social workers who were present, male and a female, assumed roles of facilitators of discussion and confrontation. They also occasionally took a devil's advocate stance in order to stimulate students to formulate attitudes toward views represented by common societal prejudices and biases, or by stereotypical male or female points of view.

This type of involvement by the school liaison social workers represented another important attempt at consciousness-raising around the child abuse problem, as well as an attempt at preventing the incidence of abuse in this population through the use of educational and group therapy techniques. In one of the high schools in which the liaison social workers were part of the alternative program for pregnant students, their involvement was felt to be essential, and they were asked to be on a community board responsible for developing a policy for the program. There was also a general interest on the part of the schools in continuing this type of class for pregnant students in conjunction with the local department of social services.

Thornton High School Group

As part of the effort to involve more school personnel in the prevention of child abuse, one of the project social workers joined a home economics teacher in designing a child abuse education proposal for secondary school students. The goals of the proposal were to increase secondary school students' current understanding of the dynamics of child abuse, the Colorado reporting law on child abuse, the availability of treatment, and to help prevent child abuse in the county. The objectives included training twelve senior high school students to give presentations concerning the problem of child abuse, presenting a child abuse education program in each of the junior and senior high schools of the school district, and educating approximately ten percent of the students in the designated school with a child abuse presentation.

As part of the implementation of the proposal, the project social worker was responsible for training the twelve senior high school students. In addition to sharing his own knowledge, he enlisted the help of various prefessionals in training the students. Included were the project's nurse, one of the project's lay therapist, the regional coordinator for Parents Anonymous, the county's assistant district attorney, a juvenile police officer, and the district's juvenile court judge. The teacher was responsible for assisting the students in selecting their method of presentation and for coordinating the assignment of child abuse presentations in the different schools. Finally, the project social worker was responsible for evaluating the program at the end of the 1975/1976 school year. The program continued functioning an additional year beyond the 1975/1976 school year.

During the course of the program's existence several innovations proved to be exciting and functional. First, as a result of the teacher's work, the students received academic credit for their participation. This demonstrated that the administration of the school supported the program idea; it also provided an incentive for students to participate. Second, the interagency and interdisciplinary cooperation strengthened and enhanced the program. The time spent by other professionals of the community in training the students demonstrated their commitment to the prevention of child abuse and it also enchanced the students' knowledge. Third, the idea that the prevention of child abuse could be aided by a peer education program proved workable. The students gave presentations to approximately three hundred of their peers, and in every presentation they were received enthusiastically. In addition, the students receiving the child abuse information acknowledged that they did not possess this information before.

There were some limitations to the program that would need to be addressed in similar future endeavors. First, the thrust of the program came from the adults involved. Students were encouraged to implement their own ideas; however, they accepted the basic proposal as outlined by the project social worker and teacher. This did not hinder the students enthusiasm, but it may have influenced their commitment. Most of the participants did not continue for longer than a year. Second, the program may have benefited from more students in the second year. Out of the ten students that participated the first year only one returned. Two new students became involved the second year; however, the number of participants was too small to implement the same program objective. Third, the objectives should have been changed to realistically correspond to the students' needs. In the first year there were only two months remaining in the academic year when the students started their presentations. In the second year, there were not enough students to realistically provide as many presentations.

In thinking about the future implementation of such a program some definite recommendations can be made. First, the support of the school administration, the provision of academic credit, and the involvement of various community resources should be retained. Second, the program should be time limited so as to hold the student's interest. Third, the creation of the goals and objectives of the program need to involve the students so that their interest and enthusiasm will be as high as possible. Finally, the operation and effectiveness of this program might have been increased by incorporating it within a school's curriculum.

Corporal Punishment

Colorado has a state law which permits corporal punishment to be used in the school systems. All school districts in Adams County had written guidelines on the use of corporal punishment in the schools, usually stipulating that it would be used as a last resort. However, during the three years of the project, there were several incidents of school personnel using corporal punishment and as a result injuring the children. Because injuries inflicted as a result of corporal punishment are also considered child abuse in the State of Colorado, corporal punishment was raised as an issue between project staff and school personnel. The process by which the liaison with these two school districts attempted to deal with the issue of corporal punishment seemed to be dependent upon the attitude and philosophy of the school district superintendent.

In one district, the superintendent believed that corporal punishment was a prerogative of the school personnel and to outlaw it would undermine

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the authority of the school. This was also the philosophy of a majority of the principals in that district. As a result of this attitude, the project liaison attempted to deal with the issue by encouraging the discussion of the pros and cons of corporal punishment during the faculty and student training sessions. Also during the first year of the project, a teacher in one of the districts caused injuries to a child as the result of corporal punishment. The project liaison invited the teacher's principal to the Multidisciplinary Review Team for an open discussion of the pros and cons of corporal punishment. Through these means, the liaison tried to interest school personnel in seeking alternative methods to corporal punishment. During the last year of the project, personnel changed and they discouraged excessive use of corporal punishment and encouraged the use of other methods.

In another district the superintendent was adamantly opposed to corporal punishment. Although, there was legal authority to use corporal punishment, the superintendent actively encouraged the exploration and use of alternative methods of discipline. At the beginning of 1976-77 school year the superintendent had a week-long conference for his administrative staff including principals and assistant principals and used two half-days of the conference to deal with the issues of corporal punishment. During that time, the project liaison spoke on the definition of child abuse, the definition of corporal punishment, and the legal implications of both. Other professionals were also brought in to speak to the issue of the use of alternative methods of discipline and how they could be effective in the schools.

Since the response to this part of the conference was positive, this resulted in the school district continuing to organize seminars on the different aspects of the corporal punishment issue, to design alternative methods of discipline and to teach school personnel how to implement them.

With the impetus of the children's rights movement, the recent, United States Supreme Court decision and identification of abused children, the use of corporal punishment in the schools has become a controversial issue. Because schools have traditionally used corporal punishment as a method of discipline, there is generally a resistance in the schools to reporting parents who injure their children while using corporal punishment. It was felt that in order to deal with the resistance, the school liaison at some point needed to address the issue of corporal punishment by encouraging discussion of the pros and cons of corporal punishment, encouraging exploration and implementation of alternative means of discipline and clearly outlining for the schools the difference between corporal punishment and child abuse.

Greater Understanding of Child Abuse and Willingness to Treat and Monitor Cases

As the school referral program progessed during the course of the project, and as the informal results of the program increased, a generally better working relationship developed between the department of social services and the school districts. Project staff attempted to keep the referring schools as involved as they wished to be during the intake process and the development of a case plan. If the referring school already had a relationship with the family in question, the intake social worker often looked to the school for the most effective way to approach the family. Thus, the task ofensuring the protection of the children and engaging the family in some form of treatment was facilitated by the intake social worker and the school working together.

The training of all school personnel, along with their involvement in the referring of actual cases, resulted in a greater understanding of the full dimensions of the child abuse problem. This cooperative spirit and increased level of understanding of child abuse produced a greater willingness on the part of the schools to monitor the children of those families for which social services had opened cases. The schools also demonstrated a greater willingness to offer counseling services or specialized programs to those children that social services recommended for such services as a part of the treatment plan.

The schools also showed a greater willingness to be involved in child abuse cases in three particular instances. Towards the end of the project grant, the six school districts were rotating a representative on the Multidisciplinary Review Team. Project social workers as well as protective service workers were being invited regularly to school staffings for the purpose of coordinating treatment plans on abused children. In some school districts, project social workers were able to obtain school office space as well as school time to provide treatment of abused children.

Issues

Intake/Referral Issue: School contacting the Family versus Family Center contacting the family

An occasional source of difficulty has been the issue of who should make the first contact with the parents after a child abuse referral had been made by the school. In the state of Colorado, the identity of the referral source can not be revealed. Therefore, the school is under no legal obligation to inform the family that a child abuse referral has been made. In practice, however, there were often other factors involved which prompted discussion of this issue by the schools and social services.

If a relationship already existed between the school and the family, and the family first learned of the child abuse referral when they were contacted by the intake social worker, they often felt that their basic rights as parents had been violated by the school. Their anger was often not due to the fact that a referral had been made, but that the school did not respect their relationship and call them first. Families were often certain that the referral came from the school, if their child was only seen in school before being contacted by the social worker.

The intake social worker generally deferred to the school in terms of how they wished to handle the initial contact with the family. Some school personnel did not wish to be involved with the intake process after the referral was made. There were several reasons offered by the schools for this approach. They had felt that child abuse was an inappropriate matter for a school to get involved with, other than taking the responsibility to report suspected or actual abuse or neglect. They believed that a problem of this nature was the concern of the project or social service department, and best handled by that agency.

Other school personnel chose not to become involved with the case after the initial referral had been made because they felt uncomfortable dealing with parents' anger. They believed that the social workers were better trained to deal with this type of hostility.

In other situations, school personnel stated that they always wished to be the ones to inform the family that a referral had been made. They believed that it was best to be totally open with the family in such matters, and to make it clear to the family that they had no alternative but to make the referral, based upon what they observed. In such situations the school social worker, the principal, and occasionally the nurse, worked closely to resolve the parents' anger when it was necessary.

Whatever the approach of the individual school, it was essential to discuss the decision as to how the family would be contacted. The impact on the school's future relationship with the family, or on the social service department's attempt to engage the family in treatment was definitely affected by this step in the intake process.

Role Delineation

In addition to responding according to the proper child abuse and neglect reporting procedures, the school personnel can also play an important therapeutic role. Regardless of whether the child has openly told a teacher that he was abused or whether the teacher suspects an injury was non-accidental, this is a time of crisis for the child. The teacher's legal responsibility is to immediately notify the county department of social services. Concurrent with this action, the teacher can respond to the emotional needs of the traumatized child.

A child who discloses that he has been abused experiences a sense of vulnerability. His options are to either say nothing and face the risk of being hit again at home, or to tell the teacher and then face what he perceives as an even greater risk of being hit again at home because he "ratted" on his parents. This ambivalence often gets acted out by the child telling the teacher about the incident with the request that he/she not tell anyone. It is important that the teacher recognize the child's concern and fear, but not honor his request. Often an abused child has been forced to be too responsible for adult actions, and his desire that his parents not be contacted is another manifestation of this overly responsible role. He feels that he must protect his parents from possible repercussions at the expense of safeguarding his own physical security. The teacher can play an instrumental role in removing this adult responsibility from the child. The child needs to hear a direct and clear message from the teacher that he has done a good thing by reporting what has been going on at home. In addition, the teacher needs to let him know that people at the school care about him and do not want him to get hurt again, and to insure that someone will be talking to his parents. Despite the child's overt negative reactions to this plan, the teacher can inwardly be reassured that this definitive action is very comforting to a frightened child. At all costs, however, the teacher must be open and honest with the child so as not to violate their trust relationship.

The child who chooses not to report the abuse going on at home does not have such a trust relationship with the teacher. This places the teacher in a difficult position of needing to ask an untrusting child questions to verify the basis for suspected abuse or neglect. If done empathetically, however, it can serve to strengthen a bond between the child and the teacher and be a starting point for the development of trust. This can be accomplished if the teacher conveys that his primary concern is that he cares about the child, rather than conveying a concern for facts and figures.

A natural unconsicious reaction of adults is to initially withdraw from an abused child because of their own negative feelings that are involved around the issues of child abuse. They tend to physically remove themselves from the child in order to avoid confronting their charged emotions. Although this behavior is a common defense, it can be very harmful to the child. The child is experiencing a life-threatening trauma and needs adults to be protective and understanding. If the teacher is emotionally and/or physically distant during this time, the child is quick to interpret his behavior as a rejection, thus leaving him painfully alone in a frightening world.

There remains the possibility that the suspected abuse was indeed accidental and this can be verified in the social worker's intake evaluation report. This did not occur very often, as verified by the project statistics, but nevertheless, it is an issue to be explored. In such a case, it is important that the teacher make more time to talk to the child about what happened. It is best if the teacher stresses how pleased he is to know that everything is okay for the child at home. Most teachers' normal tendency is to be defensive about their inaccurate suspicion, and consequently attempt to explain to the child why they made such a report. This is not necessary and can be destructive. It is best to share the feelings of relief about the positive findings.

Feedback to the Schools

One continuing issue in relation to the schools is the complaint that school personnel frequently do not hear about a child abuse case after it has been reported. This complaint appears to be chronic and pervasive in all communities, no matter what efforts are made to improve the process. Although the Project's School Referral Program provided a mechanism and encouragement of such feedback, complaints continued, although less frequently. This appears to be an ongoing problem, perhaps inherent in the interaction between two autonomous systems. The experience with the school referral program would indicate, however, that early identification of the issue and recognition of its perpetual nature may prevent its becoming a threat to the initial referral procedure. Attempts to devise a system for feedback should be continued, especially emphasizing the routine sharing of case decisions. Family Center staff facilitated this feedback by requesting to attend school case conferences, inviting school personnel to attend specific Multidisciplinary Review Team reviews, and inviting school personnel to attend Family Center research conferences when a child in their school district was being discussed. Although membership on the Multidisciplinary Review Team of school personnel can assist in this process, its effect is limited, as the school representative can directly relate to only their own school district. In Adams County they cannot be expected to be the vehicle for feedback with six school districts, expecially with the volume of cases now being reviewed.

School Liaisons

During the writing of the initial grant, it was decided that there would be one liaison per school district. This arrangement was found to be particularly effective by both project staff and the different school districts. The project staff found this effective because they became very knowledgeable about the problems and issues of their particular school district, learned how policy decisions were made, and were able to establish cooperative working relationships with the key people in each district. This allowed the project liaisons the advantage of knowing who to go to within each district to clarify a particular systems problem, how to impact policy decisions in each district, and where to refer other department of social services' social workers to clarify issues on specific cases.

The school districts also found the single liaison approach helpful for several reasons. First, it allowed each school district to relate to only one person rather than to many people within the social service system. Secondly, when the school could contact the liaison rather than having to go through the social service department's chain of command, it provided for a more efficient way of handling clarification of policy decisions and systems problems. Third, once a trusting relationship was established between the schools and the liaison, the school often used the liaison as a consultant on whether or not to refer a particular case. This allowed the school district to share the responsibility of whether or not a family should be referred and therefore, made the referral system more efficient by decreasing the time the schools use to spend making decisions on ambiguous cases.

Although the liaisons related primarily to the elementary schools, more and more consulting calls were received from junior and senior high school personnel. Because of this, it has been suggested that the liaison system be established for the junior and senior high schools, either by expanding the role of the present liaisons, or by creating separate liaison positions relating only to junior and senior high schools.

Issue of Neglect Cases

Another issue which was frequently confusing was the difference in the procedures in handling abuse and neglect referrals. The Family Center served children under the age of 13 who were referred for suspected or potential abuse. All referrals for children over 12 and all reports of neglect were handled through the Intake Unit of Adams County Department of Social Services. This was often confusing to the schools as many of their personnel did not completely understand this division of tasks or its rationale.

During the training meetings with schools, this functional division was explained, but it appeared that it continued to be somewhat confusing, expecially as new personnel were added to the schools. This was even more confusing as the protective service workers at Adams County Department of Social Services gradually took on increasing responsibility for child abuse evaluations.

In general, the schools often felt more dissatisfaction with the response and decision making process in regard to neglect cases. These cases were especially frustrating to school personnel, as the intake worker's response did not appear to be as expedient or decisive as responses to child abuse reports. Neglect cases less frequently involve placement of children outside the home, and change comes so slowly with neglectful families.

Resistance to the Reporting of Child Abuse

Despite the increase in child abuse referrals from all of the school districts in the country, some school personnel continued to resist reporting child abuse. Because the law is more explicity about physical injuries, the resistance occurred more often with suspected abuse, emotional abuse, and sexual abuse.

This resistance centered on three concerns that school personnel seemed to have about reporting child abuse: 1) Will they be supported by the school administration in making the report; 2) Can social services realistically help the family being reported; and 3) What will the parents do if they realize that the school reported the abuse.

During the course of the project, teachers, school social workers, and school nurses frequently expressed their concern about principals advising them to not report suspected cases of child abuse. These school personnel were in a very conflictual situation because they knew that the law mandated them to report such cases. The project staff attempted to intervene in these situations by consulting with the principal and the reporting person.

School personnel were also hesitant to report suspected child abuse because they did not believe that social services could realistically provide services in some cases, and they were aware of high caseloads for protective service workers. They were also aware that in most cases of suspected abuse, parents could not be forced to get treatment. They also may have remembered one bad experience that they had with social services in the past, and they assumed that this experience would be repeated. They reasoned that they would only be jeopardizing their relationship with a family if they reported suspected abuse and the family refused help from social services.

Although the project and Adams County Department of Social Services maintained the confidentiality of the reporting person, school personnel feared that parents would learn the source of the report. This fear was occasionally realistic considering the natural sequence of the response by the project or social services. If a child told his parents that he was examined by the school nurse, and at the next moment the protective services worker knocked on the family's door, it would be fairly obvious to the family who originated the report. Because of this, school personnel were afraid that a child might be reabused, that parents would pull their children out of school, that parents would no longer cooperate with the school, or that the parents might sue the school. This latter concern about possible litigation was addressed in the Colorado Children's Code by a section regarding "Immunity from Prosecution." The law explicitly protects anyone making a report in good faith without any maliciousness involved. Project social workers, assigned as school liaison, achieved some success in lessening the other fears, by explaining that reporting suspected child abuse was mandatory, by demonstrating quick response time, meaningful feedback, and cooperation with the schools on a treatment plan. The fears of school personnel were not entirely diminished, however, in regard to marginal cases, where there was not enough evidence to involve the court and the parents resisted any treatment.

Outcomes

Over the course of the Family Center project, school liaisons from the Family Center staff were responsible for providing inservice training on child abuse to their assigned school district. The interest and cooperation of school personnel in this effort is reflected in the following data on school personnel's participation in this training.

TABLE 1

SCHOOL PARTICIPATION IN FAMILY CENTER
INSERVICE TRAINING ON ABUSE
(1974 - 1976)

	Total Number All Districts	Number Inserviced	Percent Inserviced
Elementary Schools	61	58	(95%)
Principals	58	50	(86%)
Classroom Teachers	1559	1183	(76%)
Support Personnel	336	173	(51%)

A questionnaire was administered to four of the school districts prior to conducting the inservice training to gain some information about: prior training on child abuse provided to school personnel; their knowledge of and contact with abused children in the school; reporting procedures followed;

and community resources used. A follow-up questionnaire was distributed at the end of the school year to determine what changes had occurred in the school personnel's knowledge of abuse and reporting procedures in their particular district. In these four districts, an average of 78 percent of the classroom teachers and 98 percent of school principals participated in the training. The results of the pre- and post-inservice training questionnaires provide the following information.

1. Prior to the inservice training provided by Family Center staff, no more than 30 percent of the respondents to the questionnaire in each of the districts had received previous training on child abuse. Over 70 percent of the respondents to the questionnaire administered at the end of the school year had participated in the inservice training provided by Family Center staff.
2. The training provided appears to have raised a question among school personnel as to whether or not they consider child abuse a problem, and also whether they had actually encountered an abused child in their class or school. Prior to the inservice training, a fairly high percentage of the respondents in each of the districts noted that they did consider child abuse a problem and that they had encountered an abused child in their class or school (41 percent to 54 percent). On the follow-up questionnaire the percentage responding affirmatively to these two questions went down, and the percentage responding "don't know" rose. This data was consistent in each of the school districts.
3. The inservice training did provide school personnel with a reporting procedure and knowledge of state required reporting forms. When asked on the pre-inservice training questionnaire who in the school district was responsible for receiving and processing reports on suspected cases of child abuse, the responses varied from school secretary to

school principal. The responses to this question on the follow-up questionnaire named the personnel responsible for the reporting procedure that had been established in the district during the school year. Also, school personnel's knowledge of the existence of state-required child abuse reporting forms in their school increased.

4. The inservice training did provide information on the Family Center program resulting in the project being utilized as a resource by school personnel. When the School Referral Program began, the Family Center was a new community resource and had been used very little or not at all by the schools. The results of the post-inservice questionnaire indicate that, in three of the four school districts, the Family Center was one of the three agencies most frequently used as a resource by the schools during the school term. On the pre-inservice questionnaire, the Family Center was not listed by any of the school districts as one of the top three resource agencies in dealing with child abuse.

Pattern of Referrals from the Schools

The following table shows the pattern of referrals from the schools for the 1974, 1975, and 1976 school years. Over the course of the three project years, the percentage of abused and potentially abused school age children referred by the schools was substantial, ranging from 35 percent in 1974 to 47 percent in 1975 and back down to 36 percent in 1976. The school personnel making the referrals also showed a fairly accurate diagnosis, with an average of 82 percent of these children being later designated as actual or potential abuse cases by the Family Center social worker completing the intake.

A comparison of the total number of referrals from the Adams County School Districts prior to the inception of this program with total numbers in

1974, 1975, and 1976 when the Family Center had major intake responsibility and was heavily involved in school liaison work shows a marked increase in referrals by the schools:

TABLE 2

TOTAL REFERRALS FROM THE SCHOOLS

School Year	School Referrals Total
1973 School Year (Prior to Implementation of School Referral Program)	11
1974 School Year	41
1975 School Year	111
1976 School Year	113

TABLE 3

PATTERN OF
CHILD ABUSE REFERRALS
MADE BY THE SCHOOLS
(1974, 1975, 1976 School Years*)

	1974 - 1975		1975 - 1976		1976 - 1977	
	Number	Percent	Number	Percent	Number	Percent
Total Family Center Referrals Involving School Age Children (5 to 12 years)	116	100	236	100	317	100
Family Center Referrals Made By The Schools	41	100	111	100	113	94
- Actual/Potential Abuse	29	71	101	91	94	83
- Not Abuse	5	12	10	9	19	17
Percent of Referrals Involving School Age Children Made By The Schools	35%		47%		36%	

*September through June.

Adaptation

The Family Center School Referral Program was a program that the schools sought to continue upon the termination of the project. The Adams County Social Service Department also had a strong commitment to continuing the effort. Thus, six social workers under the guidance of the Protective Services Resource Coordinator are planning the continuation of this program. The Family Center liaison to the school districts reviewed the policies and procedures with the new liaisons and planned meetings with district personnel so that they could have an introduction to the district. The transition of this program area has progressed smoothly.

Over the life of the project, many requests were received for written material and personnel consultation. The school systems in Colorado appear to be much more involved than before in a concern for providing intervention to abused and neglected children and their families. It would appear from this experience that, if mutual understanding, good communication and feedback systems can be established, that two systems can work effectively together and result in more services and support for families.

CRISIS RESPONSE INTAKE

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Introduction

One of the major goals of the Family Center Project was to increase the number of reported cases of child abuse in Adams County. In the project's first year of operation, there was a 125 percent increase. This achievement was due to several variables, such as increased knowledge and awareness of child abuse in the community; the project's School Referral Program; and local publicity through the media regarding issues of child abuse. However, one of the most significant variables was the immediate response of the project staff to child abuse referrals.

The first objective designed to achieve this goal was to insure quick responses to emergent situations and to provide intake services within 72 hours to less emergent situations. During the project's first year the average length of response time was 24 hours.

Another objective of this program area was to provide a multidisciplinary consultation system for all intake cases. The Multidisciplinary Review Team was established prior to the funding of the project, and after the project began providing all child abuse intake services, the project director chaired the team meetings.

Providing immediate medical care and documentation of all injuries was the third objective of crisis response intake. To facilitate achievement of this objective a nurse was employed as a member of the project staff. She assisted the social worker during the intake phase and assured immediate medical intervention and follow-up. A more thorough review of the role of the nurse is discussed in the chapter on "The Role of the Nurse on a Child Abuse Team."

Following the identification of the program goals and objectives, the Family Center staff was trained and began providing intake services in November, 1974. Initially, the project staff provided intake services for all referred, abused children twelve years and younger for Adams County. However, alterations were made to accommodate the tremendous increase in reported cases and the Adams County Department of Social Services participated in providing intake services. This was necessary because of the time involved in providing comprehensive intake services and the project's need to develop the other program areas identified in the grant.

Methodology of the Intake Process

As an initial step in insuring that the project would be responsive to community calls on child abuse, it was decided that one person would be designated to receive the initial referral information. The importance of this was not only to be available in case of emergency situations, but also it was a relief to the community referral sources to know that they could immediately contact someone to take over direct responsibility for a potentially dangerous situation. The person that received the initial referral obtained such information as the name of the family, the abused child's name and age, the family's address and phone number, a description of the abuse, the severity, where the child was presently located, and the name and number of the referring source.

During the first few months of the project, child abuse referrals were responded to within 24 hours. With an increase in program responsibilities, the response time increased from 48 to 72 hours depending on the potential danger to the child. However, in general, "actual" child abuse cases were responded to within 24 hours and all "severe" abuse, where the child was in the hospital or in serious physical danger, was responded to immediately. From November of 1974 to March of 1975 the project was responsible for all child abuse referrals of children under the age of 12. Again, as the program responsibilities increased, the responsibility for the number of intake evaluations decreased. In March, 1975, the project became responsible for the first six child abuse intakes in each week; March, 1976 the first four intakes and in November, 1976 the project staff incorporated into a rotation system for intakes with the child protection units from the Adams County Department of Social Services.

After the initial child abuse referral, the intake was assigned to one of the project's social workers. When the social worker received the referral he/she would check for past history of abuse, and past or present involvement with the Department of Social Services. First, the worker called the Department of Social Services to ascertain whether the family had ever received services or was presently receiving services. Secondly, a call was placed to the State Central Registry at the State Department of Social Services to ascertain if they had any documented history of past abuse.

Next the referral source was contacted by the social worker. During this contact it was important to discuss more extensively the nature of the child's injury, if they had suspected abuse in the past and their estimation of the danger to the child. Also, it was discussed with the referral source what, if anything, they knew about the family history or what may have led up to abuse. It was important to find out why the referral source thought there was potential danger to the child and to ask the referral source to review their memory about suspicious incidents or behaviors.

Who should first contact the family was also discussed. Some referring persons in situations such as schools, hospitals, and health departments already had a good relationship with the family, and believed it was important to first inform the family that they had made the referral and who would be contacting them. However, this still happened infrequently, and usually the referral source asked the project social worker to make the first contact.

The initial contact by the project social worker was generally made by telephone. During this conversation, the worker identified him/herself, stated the nature of the call, and made an appointment for a home visit.

After the home visit was completed, if acutal abuse were involved, a CWS-59, the Colorado Child Abuse Reporting Form was completed. Then copies were sent to the referring agency, the National Clearing House, the State Central Registry, the police and the District Attorney's Office. In cases of severe abuse, reabuse, sexual abuse, placement of children, or cases where the worker or child needed the protection of law enforcement, a telephone call was made to the police to advise them of the abuse or to request their intervention.

Finally, a written report of the cases with recommendations for services was prepared to be presented to the Multidisciplinary Review Team (MRT). This report was made to the Multidisciplinary Review Team for their review within ten days.

Initial Contact

The first contact that a worker has with an abusive family can be stressful for both the family and the worker; therefore, the manner in which the social worker makes this initial contact can have far reaching effects with regard to the assessment of the family and subsequent treatment. In order that the initial contact be in a positive direction, the following questions should be considered; how does a worker respond to a very angry, hostile client, or to a very passive, nonverbal client? What are the best interviewing techniques to use when making that initial contact with the parents suspected of abuse? Finally, how can the worker handle his/her feelings about the nature of the abuse and the people involved, so that such feelings do not interfere with the assessment of the case?

A social worker can best handle the initial anger and defensiveness of a parent by emphasizing that the intake interview is an evaluation and not an accusation, focusing on the parent's feelings, and by remaining honest with facts and expectations.

A strong tendency for abusive parents is to isolate themselves from those persons offering help, especially if they perceive them as threatening in any way. If someone is coming to talk with them about their child being abused, their greatest fear is that someone will take their child away. It is important for the social worker, at this point, to be clear about his/her purpose. By making sure that the parents understand that the initial contact is for an evaluation and not for a trial to take their child away, some of their anger and accompanying fear can be lessened.

In addition to being honest about the purpose of the interview, the worker can also avoid heightening parent's anger by being clear and straightforward about pertinent facts such as the child's injury, the parent's strengths and weaknesses, the need for placement, and the legal expectations. The parents need to know the extent of the injury, and be given a chance to explain how it occurred. They also need to hear what the social worker initially assesses as the problem including an appropriate treatment plan. The parents may disagree, but they will protest even more if the recommendations are unclear. The need for a child to be placed in foster care may be part of the social worker's recommendation. If that is the case, the parents should be made aware of the social worker's rationale for such a recommendation. Again, they probably will not agree with the social worker, but they can then focus their anger instead of leaving it diffuse. Along with the placement of their child in foster care, the court involvement can also increase the parents' anger. It is important for the social worker to explain why the court is involved and what the parents can expect will happen during the court hearings. To interpret the court hearing as a chance for the parents to state their viewpoints and recommendations often helps the parents channel their anger constructively.

Finally, the best way that a person can deal with a client's anger over a child abuse referral is to listen and accept the feelings being expressed. The social worker can do this by being empathetic and assuring the client that his feelings are important.

A social worker encounters passive, compliant clients as often as angry, hostile ones during this initial interview, and the best response is to confront their behavior enough so that they are aware of their own feelings, the facts of the case, and the realistic expectations about how they can help stop the abuse. A passively compliant person often tells the social worker what he/she thinks the social worker wants to hear. Therefore, if the social worker feels that he/she is being manipulated he/she needs to confront the client about the facts of the case.

Besides the techniques already mentioned, there are additional ways to elicit a clients' response during the intake interview. These include: making eye contact with the parent, moving away from the abuse incident as soon as possible, focusing the interview towards the parent instead of the child, listening to both the feelings and the content being expressed, and utilizing crisis intervention techniques. Abusive parents use many defenses to avoid their own feelings, and a person can be effective in confronting this resistance by making good eye contact.

An easy trap for people beginning to work with the problem of child abuse is to continually ask, "why was your child injured?". This information is significant to know at some point during treatment, but it only serves to strengthen a parents' defenses during the intake interview. A parent's attitudes and feelings reveal their motivation, and one can discover those indirectly instead of trying to elicit them by focusing on the abuse incident.

The social worker not only can encourage the parents to lower some of their defenses by moving away from the abuse incident, but they can also make the parents less resistive by focusing the interview on the parents instead of the child. Although abusive parents do not feel comfortable in talking about their own feelings, they are even more defensive about their parenting skills.

The social worker can encompass many techniques already mentioned by always listening to the feelings and interpreting the behavior of the client. Although the content of an interview is important because it includes dates, times, places, names, and other significant facts, the heart of the matter is to gain some knowledge of how a client perceives his/her own functioning. With this latter information, the social worker begins to understand why the abuse occurred. The staffing of the project made it easier to obtain this information by involving the project nurse in the intake evaluation. As mentioned in the section on "The Role of The Nurse on a Child Abuse Team," having two people involved during the intake interview enhanced the quality of the assessment.

Finally, crisis intervention techniques can be useful and are often necessary when encountering parents during the intake interview. The techniques include the following:

1) Focus actively on precipitating events and the resulting crisis.
2) Do not react to disordered affect.
3) Have the client talk about events leading up to the crisis, and what effect the crisis is having on their functioning.
4) Help the client identify and use whatever coping mechanisms have been successful in the past.
5) Make use of supportive techniques such as acceptance, reassurance, and empathy.
6) Help individual recognize, organize, and distinguish a realistic plan or solution for the crisis.
7) Take an active and directive role, especially in finding resources for people.
8) Direct all of your energy towards the resolution of the crisis.
9) Reinforce client progress.
10) Give some assistance for future planning.

Content of Evaluation

Because of the crisis nature of abuse intakes it was often difficult to obtain extensive information in all areas. However, an initial assessment was attempted in eight major areas.

Initially, it was necessary to focus on the injury to the child. The project nurse first made an assessment of the actual injury and whether the explanation was consistent with the injury. She attempted to obtain some past medical history to determine if the child had received adequate medical care and to determine if there were past unexplained injuries. Finally, a developmental evaluation was completed on the child assessing such factors as gross and fine motor skills, language, cognitive skills and attachment to the parents.

As soon as possible, an attempt was made to focus the interview on the parents. It was important to find out what the parents saw as the presenting problems that led to the abuse. Were they seeing the abuse as a result of some negative behavior by the child, environmental problems, or relating the abuse more directly to personal or marital problems?

In order to clarify what led to the presenting problems, it was important to obtain some family history, looking for the presence of abuse dynamics. The areas focused on for the family history were the parent's childhood, adolescence, marriage and child rearing years. Some specific factors focused on were such things as the perception of the parents about their own childhood and relationships with significant others, including what methods of discipline were used and if they were ever abused. Also, the present relationships with the parents' families were explored. Next, questions were directed toward the marital situation - when they got married, why they got married, and how they felt about marriage and their spouse. Finally, it was determined when and how they made the decision to have children, how they felt about having children, how the pregnancy and early years of the children were perceived and how they felt about this period of time. At the same time, a determination was made on the expectations they had of their children, how the parents' needs were or were not getting met, and what kind of discipline method was used most often.

The parent's isolation was also explored. Did the parents have relationships that extended outside the immediate family? What were these relationships like? Did the family know how to use support systems when they had problems?

Were they able to count on any extended family for support? Were they isolated physically by having no transportation or phone.

During the time that this information was gathered, the social worker was also attempting to assess the attitude of the alleged abuser. What was the alleged abuser's reaction to the abuse? Did he deny the abuse, did he see it as an acceptable means of discipline or did he express remorse or concern for the child? Did he basically feel positively toward the child or did he see the child as intrinsically bad and having serious behavior problems? Also assessed was the alleged abuser's willingness to involve himself in treatment. Was he admitting the abuse, but denying any problems or need for treatment services or was he accepting some responsibility for the abuse and either requesting services or not actively resisting them?

As the social worker assimilated the information gathered from the family, an overall evaluation was made of the families' strengths and weaknesses. This included looking at areas in which the family functioned adequately, areas in which they functioned poorly, stresses that seemed to create crisis for the family, how effectively they used the support systems that they had and how, in general, they responded to the intervention by the social worker.

This segment of the evaluation was essential in determining whether the child was in imminent physical danger and in need of placement. Besides the families' strengths and weaknesses, consideration was given to the age of the child, the extent of the injury, the attitude of the alleged abusers, and the safeguards that could be provided to the child within the family context. The assessment for the placement of the child will be discussed in more depth in the next section.

Assessment for Placement

During the course of an intake evaluation, one decision that had to be made was whether or not the child was in need of placement. Some guidelines were developed that were considered in assessing the risk to the child. The first factors considered were the age of the child, and the type and severity of the injury. In general, any child under the age of five was particularly vulnerable, because these children were less visible to the community and were less able to defend themselves. More caution was applied with infants under the age of one year. Broken bones, burns, head injuries, and severe multiple bruises implied violent outbursts and less implulse control and, therefore, there was a greater risk to the child. In these cases, because a non-medical person could not determine if the explanation was consistent with the injury, the project nurse examined the child. In certain intake cases, upon the recommendation of the project nurse, a physican also examined the child. The social worker also questioned whether the injuries were a result of loss of control or methodical torture.

Another area that was considered was the precepitating factor of the abuse. If the family was involved in a crisis that would take sometime to resolve, abuse was more likely to occur. Abuse was also more likely to occur if the abuse was a result of the child's behavior which was likely to continue and which the parents considered intolerable.

The parents of the child and any other adult member of the household also needed to be evaluated. Did the alleged abuser deny the abuse, admit the abuse but express concern for the child, or admit the abuse but felt that it was necessary and justifiable discipline? If the parent admitted the abuse and felt concern for the child, did he/she have any insight into the problem?

Could he/she recognize potentially dangerous situations in time to seek help and relief? Did he/she have resources or know where to go to seek help and relief? Also, how did the passive abuser or other adults in the family react to the abuse? Did they justify the abuse and side with the alleged abuser or did they express concern for the child? Did they recognize potentially dangerous situations, and were they capable and willing to intervene to protect the child?

Equally important was the attitude and perception of the alleged abuser toward the child. Abuse was more likely if the parent did not see the child as a separate person, because the parent then did not perceive the child as having needs and feelings of his own, but as only being there to gratify the parent. Did the parent have exorbitant expectations of the child or perceive the child as bad, evil or possessed? If this were the case, the child was usually not able to please the parent and, therefore, more likely to be abused. Was the child in a particularly difficult developmental stage, or did he have some physical or medical problems that demanded more time and attention from the parent? Finally, did the family blame the child for the intervention from the project? If they did, this may precipate further abuse to the child when the social worker leaves.

If most of these factors were present in any family, it indicated that the potential for further abuse was high and that placement was necessary.

In any situation where involuntary placement was necessary, law enforcement officers needed to be involved. In the State of Colorado, a police officer was the mandated person to take a child into protective custody. In the majority of the project's intakes, common practice was for the social worker to do the initial evaluation and then call the police if necessary.

The police would determine if there were probable cause, if so, take the child into custody, and the social worker would make the placement. In very severe cases, where children were hospitalized or in some cases of actual sexual abuse, police officers were often the first individuals to interview the family. In these cases, the social worker provided services following the police investigation. If criminal charges were filed and the parents were in jail, interviews with the parents were often not permitted and the function of the social worker was to provide placement and services to the child. If an investigation was pending or the police decided not to press charges, the social worker's function was to place the child and make treatment plans for the entire family.

Although initially strained, a cooperative relationship between the project social workers and the police officers of the various communities in Adams County was eventually developed. It was developed to the point that in some cases of mild abuse, the police officers would rely on the social worker's evaluation and simply make a report of the social worker's call without initiating any formal police investigation. Also, the police were very cooperative in participating in intake evaluations with the social workers for those cases where the referral information indicated probable placement and/or indicated some probability of violent behavior by the parent.

Voluntary placement was also used by the project social workers. Voluntary placement did not need police intervention, but required the parent to sign a voluntary custody consent form. Voluntary placement was usually utilized in two kinds of situations. The first situation usually involved potential abuse, where the parent feared he/she would hurt the child if he/she did not receive some type of immediate relief. The second situation commonly involved cases of situational abuse involving mild to very moderate abuse and with no

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past history of abuse. In these cases, the parents were agreeing to the provisional relief. In both these situations, the family was usually in some kind of immediate crisis that needed to be resolved before a safer atmosphere could be provided to the child. In general, the goal of this kind of placement was to help the family resolve the crisis as soon as possible, so that the child could be returned home.

Interpretation and Expectations

At the end of the evaluation interview, the social worker would talk about interpretations and expectations. The information provided included relevant points from the state child abuse law, social service intervention, the medical findings concerning the child's injury, foster care arrangements, court hearings, and additional treatment resources. The treatment issues included the social worker's assessment of the family, and the prescribed appropriate treatment method. This process was important in order to avoid misinterpretations or the development of mistrust. It helped to insure that everyone's expectations of each other were clear and understood. Many parents were concerned about who had referred them, and they demanded that the social worker identify the name of the referral source. The project social workers responded by explaining the Colorado Child Abuse Reporting Law would not allow them to reveal the source of the referral.

It was very important that the parents be informed about and understand the extent and nature of their child's injuries as well as a medical opinion about how the injuries occurred. They needed to be confronted, if their explanation of how the injury occurred was inconsistent with that of a doctor or a nurse. They also were advised that if this inconsistency was a part of the rationale for possible foster care placement and the filing of dependency and neglect court petition.

If therewere going to be a foster placement, the parents usually had many questions about the length of stay, the identity of the foster parents, and visitation with their child. The social worker answered these questions honestly and openly. As already mentioned, the parents may not have agreed with the rationale for placement, but at least the communication was clear and they were advised of what was expected of them.

The social worker explained the court process with regard to time and dates for court hearings, the parents' and child's right to be represented by an attorney, and the difference between a civil and criminal hearing. Most of the project's child abuse intakes were handled in juvenile court. Parents were advised that the intent of the court's involvement was to protect the child and to recommend counseling and treatment for the family.

In approximately 26 percent of the project's intake cases, social workers believed it was necessary to involve the court. They decided to involve the court based upon the severity of the abuse and the parents' amenability for treatment. Social workers involved the court by filing a Dependency and Neglect petition in which the child was alleged to have been abused. This was a petition in the civil court, used for the purpose of protecting children, and insuring that their best interests were being served. As a minimum result of this petition being filed, the court could order a child to be supervised at home. As a maximum result, the court could order that the parental rights be terminated. Unless the project social workers continued to treat the family beyond the intake phase, they usually participated only in the initial court hearing, known as a detention hearing. The detention hearing was required in those cases that involved an involuntary placement of a child, and it was held within seventy two hours of the child being taken into protective custody.

At the detention hearing the judge decided whether a child should remain in protective custody or should be returned to the parents' home based upon the testimony from the intake social worker and the parents.

It should be noted that the detention hearing was only for that purpose and the allegations concerning the abuse were considered at a later hearing called an advisement hearing.

The social worker helped the parents focus their energy on actual problems and realistic solutions. The social worker discussed the parents' behaviors, communication patterns, feelings, methods of problem solving, and any other factors that were causing them discomfort and contributing to the child abuse. The social worker's interpretations were supportive and yet confronting so that the parents' resistance could not interfere with their seeking help. In addition, possible modes of treatment were explained so that the parents could understand and choose a type of treatment that was comfortable for them.

Also, the social worker shared information about resources in the community for therapy as well as concrete services. This information was most helpful when the social worker explained the services that offered the most benefit and that were realistic for the family.

Services Provided During Intake

The project social workers shared information with the families or referred them to specific agencies; however, in some cases they actually assisted the family in obtaining a particular service. They explained such concrete services as day care, public assistance, emergency finances, housing, and food stamps that were available at the Adams County Department of Social Services. They referred families to medical resources that included Tri-County Health, private physicians, and local hospitals. In some cases in which a mental health evaluation was needed, they referred the families to the Adams County Mental Health

Center. They referred families to private therapists, when recommendations were made for additional psychotherapy or specific treatment services that were not offered through the local public agencies.

Collateral Contacts During Intakes

During the course of an intake evaluation, the social worker attempted to obtain as much information as possible about the family's past and current functioning. Much valuable information was obtained by talking to those people who presently were in contact with the family, or had been in the past. These resources included mental health centers, public health agencies, other medical personnel, other county departments of social services, schools, friends, neighbors and relatives. In general, the procedure was to ask the families to sign a release of information form and to ask them who might be helpful for the social worker to contact. In the majority of cases, the families were quite willing to sign the release forms.

The collateral contacts were useful not only for fact gathering, but also helped in confirming or altering the speculations or emotional reactions that the social worker had toward the family. Furthermore, these contacts helped the social worker clarify the inconsistencies, inaccuracies, or distortions present in the interview with the family. Finally, it was essential to assess which collateral resources were presently providing services to the family, so that a cooperative treatment plan could be initiated for the family.

Supervision in Intake

The Family Center Project provided all intake services for child abuse referrals of children twelve and younger during the project's first five months of operation. During that time and up until August, 1975, the project director was responsible for supervising all project staff. Providing intake services

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was very demanding due to decisions to be made, community pressure, and often hostile clients. The project director was not as available as much as would have been ideal for supervision. The project staff learned that immediate and supportive supervision was essential in this program area. Thus a project supervisor was employed in August, 1975.

There were three main goals in supervising the project's social workers who provided child abuse intake services. The first goal was to assist the workers in providing immediate, appropriate responses to the intake referrals. This was accomplished by having the workers assess the referral information in relation to the severity index. Using the severity index as a guide reduced the worker's anxiety around which cases required immediate personal contact and which intakes could be placed lower on the priority list. The project social workers had many other program responsibilities, and the supervisor assisted them in setting these priorities. Once priorities were clearly defined by the workers, their response to intakes was more effective.

The second goal of supervising social workers providing intake services was to assist in the process of a thorough evaluation and the transition of the case. The project social workers had the responsibility of assessing the validity of the referral, and providing their evaluation results to the Multidisciplinary Review Team.

The supervisor reviewed the initial telephone referral information and assigned the intake to one of the project social workers. There were several variables involved in making the assignments. The first was to consider who was next on the rotation list. Secondly, what intakes had the workers recently received? This was an important consideration in not assigning another serious abuse case to a worker that had just completed one. It was important to vary the assignments along the continuum of the severity index. The third variable was related to the individual worker's strengths and limitations. Some workers were more experienced and seemed to be better able to handle serious cases. The fourth consideration was the worker's particular situation at any given point. If a worker had had a treatment case in crisis, or was going on vacation, or was heavily involved in another program area, that next intake was assigned to someone else. The project social workers were comfortable with these variables and worked with each other in the spirit of camaraderie.

Encouraging the social workers to be open about their feelings in supervision was the third goal. Providing intake services to clients who were often hostile and working with some agencies who may have not been cooperative in the evaluation stimulated feelings for the intake social workers. It was important for the social worker to have a legitimate forum to express and to plan for resolution of these feelings. The supervisor attempted to use these counter-transference feelings diagnositcally to determine the depth of the families' problems, and to assess the needs of the other agencies involved in a constructive manner.

Another process that was helpful in enabling the social workers to be open was to be an active listener. This was accomplished by actively listening and responding to the intake evaluation presentation; by having empathy for the worker's feelings; criticizing in a constructive manner; identifying the worker's growth; and by reinforcing the worker's appropriate use of techniques and interpretations.

In the process of reviewing intake evaluations with the project social workers, the supervisor related to two areas; the content of the evaluation and the process or method of the worker's presentation.

The content of the evaluation involved the family history, family interactions, social interactions, and the strengths and limitations of the individual family members. Additional information discussed in the supervisory conferences has been presented previously in this chapter.

One process issue was the worker's emotional reactions as he/she was presenting the content. Often the emotional response of the worker appeared to have validity in completing child abuse intakes. If a worker were presenting facts that appeared to describe a basically well adjusted family, yet the worker's affect was one of apprehension and skepticism, the worker's emotional responses needed to be explored further, and some follow-up evaluation might be needed.

There was a second process issue that ran parallel to the above. It was essential that the supervisor also assess the depth of the evaluation. Sometimes workers developed patterns of work and evaluation styles. As soon as a pattern varied and a worker presented a case in a different style, it was valuable to explore in supervision why that variance was occurring. It was often an overreaction either in a negative, punitive way, or an overidentification with the family by the worker. Both needed to be explored and used diagnositcally.

Another important task of the supervisor in relation to intake services was to be available to the social workers. When particularly difficult situations would arise in an intake evaluation, it was helpful to discuss with the supervisor alternatives, the need for placement of the child, or other serious decisions.

Issues Involved in Intake Process

Philosophical Differences in Approaching the Intake Process

Over the life of the project, significant differences arose in the manner in which different social work staff approached the intake process. Since controversy and confusion have often surrounded the process of providing child abuse intake services, some discussion of different approaches that project staff have used is warranted. Essentially, the staff used two approaches: one which was a very specific and direct evaluation of the abuse referral, and the other which was crisis intervention approach.

Both approaches were concerned with an assessment of the allegation of abuse, the first was more time limited. The primary purpose of intervention was viewed as fact gathering. Following is a list of questions addressed: 1) Were a number of the child abuse dynamics present? 2) Was there an injured child? 3) Did the alleged abuser present a history of abuse as a child? 4) What kind of physical punishment was routinely used as a method of discipline? 5) Were the parents in a time crisis due to unemployment, financial hardship, or other types of family problems? 6) Did the parent possess little knowledge regarding child development, parenting skills? 7) Did the parent have unrealistic expectations of the child? or 8) Did the parent appear to be socially isolated with no support systems?

Assessment was made of whether or not a profile of an abusive or potentially abusive parent was present. The intake social worker proceeded to evaluate the possibility that the child in question had been non-accidentally injured. If this were the situation, the social worker assessed the potential for further physical harm to the child, specifically weighing whether or not placement of the child out of the home was necessary at that time. There was also an assessment of present and past problems, and of where the family could most appropriately obtain services.

This process generally did not involve more than two meetings with the family and often was accomplished in one. The underlying philosophy for this intake process related to two factors found in abusive parents: 1) their propensity toward immediate transference reactions, and 2) their sensitivity to loss or change. The longer the intake process, the more likely a transference reaction would occur and the more difficult it was for the client to change to another social worker for treatment services.

The major way that the second approach to the intake process differed from the first approach was the addition of more involvement in the relationship between the client or the worker. An attempt was made to develop an alliance or relationship with the family. Attention was given to resolving a crisis that the family was embroiled in, if it had an impact on the abuse incident.

If appropriate, concrete suggestions as to how to deal with the crisis were made. If marital problems appeared to be at the root of the abuse incident, there was in-depth discussion of those problems. If a lack of knowledge of child development appeared to be involved in the problem, some time during the intake process had an educational focus. In summary, this approach takes a broader view of the role of the intake worker. It goes beyond assessing the degree of danger to the child and initiating appropriate action, to developing a trust relationship with the family, and initiating the treatment process. The time involved in this approach was considerably longer than was involved in the first approach. At times, as many as four or five contacts occurred over a two- to three-week period before transferring the case to the protective service social worker who did provide the treatment.

Some social workers view intake evaluation and treatment as being separate and distinct processes. Confusion or overlapping of the one with the other is viewed as undesirable and as weakening the efforts involved in the separate processes. The more the two are kept separate and the different issues in the two kept clearly delineated, the more effective and efficient the intake evaluation will be, and the better the chances are to engage the family in a productive treatment experience.

Others do not view the distinction between the two as existing. They are more likely to believe that as soon as the initial contact with the family is made, active intervention begins. There is no distinction made between assessment of the abuse referral and the development of a treatment alliance with the family. It is felt that the two cannot be effectively separated from one another, and that these initial contacts do not have to be limited to assessing the abuse incident in question. Rather, the time can be used to deal with other issues, possibly more substantive in nature. It is also believed that since families are often experiencing pain at the point of intake, and are therefore feeling vulnerable, they will be more receptive to outside intervention.

Use of Concrete Services During Intake Process

Another issue which arose around the intake process involved whether or not the social worker could become involved in helping the client obtain concrete services: The question was whether this was an appropriate part of the intake evaluation process.

In some instances when an intake social worker goes out to complete the intake evaluation, he/she will find the client in a state of crisis, which may or may not relate to the abuse incident. In families functioning at a subsistence or below-level, crises could relate to a need for money, food, shelter, furniture, medical care, etc. The question at that point becomes whether or not the social worker views it as his/her function to become instrumental in helping the client obtain public assistance, food stamps, housing resources, a hospital, clinic, etc.

The social worker who views the intake process solely as a time to assess the referral, the potential danger to the child, the needs of the child, and refers the case on to a treatment resource if necessary, will not consider it appropriate to become involved in the direct or indirect provision of concrete services to the client. This is based upon the theory that intake is not the time to become involved with the family beyond the parameters of the initial assessment of the referral.

The intake social worker who perceives crisis intervention as a legitimate part of the intake process will be likely to become involved in the provision of a direct service if the need is present. A situation where such a need would be present does not occur that often, and generally a client or family would have to be virtually without resources for the social worker to assume this kind of direct involvement. An assessment of the real vulnerability and need of the client is necessary. Otherwise, the social worker might be fostering the dependency of the client by assuming responsibilities for him which the client is capable of assuming for himself. If the social worker perceives the need for the concrete service to be directly related to insuring the protection of the child, and the need for the service to be genuine, he/she would be more likely to work toward providing the service.

Issues Involved in Community Agency Referral Sources

There were few resistances encountered in getting other agencies in the community to report cases of actual or suspected child abuse. Through the School Referral Program and the public education efforts, the awareness of the need to report child abuse was heightened, and the number of referrals increased significantly. The issue of some public agencies' resistance to becoming involved in child abuse problems beyond their basic legalistic responsibilities was raised by the project staff. This was certainly not the case with most agencies, but there were those instances where an agency which was in the position of being able to become involved in an abuse case adopted a position of noninvolvement. The rationale in this type of situation most often was that child abuse was a legal matter, and more appropriately the concern of the project, social services, or law enforcement. This attitude was not representative of the concept that child abuse is a community problem, not just a specialized concern of one agency or one part of the community.

Another issue involved in working with other agencies was in regard to the feelings of the referring person.

Feelings of possible overidentification with the abused child, overreaction to the injury and abuse incident, or real anger at the parents if the injury was of a moderate or serious nature occurred. The intake social worker tried to be a facilitator in helping the person discuss his/her feelings about the incident, so that he/she would be better able to be objective and less likely to overact when the matter was discussed with the parents. There was a need for close working relationships with the referral sources to ameliorate a difficult situation for all concerned and to preserve as much as possible the agency's relationship with the family.

In many cases the referring agency had a rapport with the family and a knowledge of the dynamics of the situation. This relationship was an important one to the development and implementation of a treatment plan. If the referring agency was not kept informed about the case, a potentially helpful resource for the family was lost.

The Initial Contact with the Family

Two issues developed with regard to the initial contact with the family after a child abuse referral has been received: 1) who should tell the family that a referral had been made, and 2) should a call even be made prior to making the first contact with the family.

Problems arose when an agency made a child abuse referral, and the family first learned of this from the project intake social worker. The families became irate not only because a referral was made, but also because they were not informed of this by the involved agency, with which they previously felt they had a good relationship. They felt that their relationship with the agency was compromised, and that they at least deserved the courtesy of being informed by the agency that this action had been taken.

In some instances, this contact was not made because the agency felt uncomfortable handling the anticipated anger of the family, had little relationship with the family, felt that it would not make any difference, or was not provided the option of making the first contact by the intake social worker. Regardless of the reason, the result was often damaging.

The issue of whether a telephone call should be made prior to initial contact arose over the life of the project. Some social workers believed that the family should always be informed prior to unannounced visits and others did not.

Those favoring the first approach believed that calling the family before making the home visit was not only a matter of common courtesy, but also that informing them of the referral helped them prepare psychologically for the intake evaluation immediately following the contact.

Social workers who did not telephone first believed that the possible harmful effect of a planned visit to discuss a child abuse allegation far outweighed any considerations of courtesy or convenience. A call from the intake social worker or from the referring agency could stimulate the parent's feelings that he/she had been unfairly accused or was labeled a bad parent or could stimulate fears that his/her child could be taken away.

Transferring of Intakes

After the Family Center's intake evaluations were completed and the decision was made to open a protective service case, there were problems regarding the time lag in the protective service worker providing services. They were often not able to assume an active involved role in the case for anywhere from three to six weeks. Cases of a more serious nature or where placement and court action were involved, often received more immediate attention. However, when significant amounts of time did lapse before follow-up contact was made with the family, the client's readiness for help developed during the intake process was lost or seriously weakened. Often the impact of this was that there was great difficulty in developing a therapeutic alliance with the family.

Another result of the prolonged time lapse between intake and the beginning of treatment was that the client frequently continued calling the intake social worker, asking for some help or assistance. This made it difficult for both client and project social worker to terminate their relationship, especially if the family was in a time of crisis.

This issue involved several factors: (1) problems inherent in having a separate intake unit and: (2) the difficulty of getting to new cases in an optimal amount of time for social service departments who have large caseloads and overworked staff. When one social worker completes the intake evaluation, and another the treatment, a lack of continuity can occur if the transition does not take place quickly.

Regarding the second factor, there is no blame to be placed upon individuals for not responding to cases sooner. Rather, the social service system needs to assess the effect its large caseloads have on families being served. This has been an issue during the course of the project, and will probably continue as an issue until system wide changes are made.

Counter Transference Issues

Involvement with child abuse at any level, whether at the point of intake or during ongoing treatment, can be difficult for the child welfare professionals. Aside from the difficulty of seeing a child who has been mistreated, or working with parents whose emotional needs are often greater than those of their children, there is also the matter of those feelings or memories stirred up in the social worker about his childhood, the parenting he received, and what kind of relationship he has with his parents. It is very difficult not to be affected in some way by the child abuse problem since it strikes a common theme in everyone. That theme is whether professionals feel they have received the nurturance and love during their childhood which was needed.

This issue is an especially critical one for the intake social worker. At the point of intake, the abusive parent is often in a time of crisis, or is feeling particularly hostile or defensive. Inwardly, he might be feeling very needy, but is masking his true feelings with abusive or abrasive external behavior. If the social worker allows himself to respond to the parent's anger abrasively, he will be unable to make an objective evaluation. Or, if the social worker finds himself/herself over-identifying with the abused child, and overlooking the position and needs of the parents, he/she will have little hope of making an objective evaluation, and developing any kind of a therapeutic alliance with the parent.

Outcomes

This section analizes the six areas of the Crisis Response Intake process for which data were collected over the life of the project. These areas include:

1. The Intake Process
2. Parents' Perceptions at Intake
3. Precipitating Crises
4. Abuse Dynamics
5. Special Data Collection (Category of abuser and parent loss)
6. Demographic Data

The Intake Process

Response Time: A comparison of the first and second year response time by Family Center staff to child abuse intake shows a consistently good response time on intakes involving actual injury to the child. During the first project year, 81 percent of acutal abuse cases were responded to in one day or less, and during the second project year, 78 percent of actual abuse cases were responded to in one day or less. Both years, all actual abuse cases were responded to in five days or less. Refer to Tables 1 and 2.

For potential abuse cases, the response time was longer. However, the majority of potential abuse referrals were responded to in five days or less in both years. During the first project year, 73 percent of the potential

TABLE 1

CRISIS RESPONSE INTAKE

(November, 1974 - October, 1975)

TIME LAPSE	ABUSE		POTENTIAL ABUSE		YEAR END TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Intakes Responded to (Total)	111	(100)	120	(100)	231	(100)
Same Day	73	(66)	47	(39)	120	(52)
One Day	17	(15)	31	(26)	48	(21)
Two Days	7	(6)	14	(12)	21	(9)
Three Days	3	(3)	6	(5)	9	(4)
Four Days	5	(4)	6	(5)	11	(5)
Five Days	0	(0)	8	(7)	8	(3)
Six Days	4	(4)	1	(1)	5	(2)
Seven Days	2	(2)	4	(3)	6	(3)
Eight Days or more	0	(0)	3	(2)	3	(1)
Intake Process Completed *						
Five Days or Less	15	(13)	14	(12)	29	(12)
Six to Ten Days	23	(21)	23	(19)	46	(20)
Eleven Days or More	50	(45)	50	(42)	100	(43)
Information or Case remained at Family Center	23	(21)	33	(27)	56	(24)
Contacts During Intake Process **						
No Contacts	9	(8)	12	(10)	21	(9)
One Contact	23	(21)	27	(22)	50	(22)
Two Contacts	23	(21)	42	(35)	65	(28)
Three Contacts	23	(21)	13	(11)	36	(16)
Four or More	33	(29)	26	(22)	59	(25)

* The intake process was considered "completed" when the case was transferred to the Adams County Department of Social Services for ongoing services.

** "Contacts" is defined as person to person contacts with the client or other individuals involved in the intake, which may include other family members, police, hospital personnel, etc. "Contacts" does not include telephone contacts.

TABLE 2

CRISIS RESPONSE INTAKE

(November, 1975 - October, 1976)

TIME LAPSE	ABUSE		POTENTIAL ABUSE		YEAR END TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Intakes Responded to (Total) *	40	(100)	42	(100)	82	(100)
Same Day	19	(48)	14	(33)	33	(40)
One Day	12	(30)	2	(5)	14	(17)
Two Days	4	(10)	6	(14)	10	(12)
Three Days	3	(8)	5	(12)	8	(10)
Four Days	1	(2)	4	(10)	5	(6)
Five Days	1	(2)	1	(2)	2	(2)
Six Days	0	(0)	4	(10)	4	(5)
Seven Days	0	(0)	2	(7)	3	(4)
Eight Days or More	0	(0)	3	(7)	3	(4)
Intakes Process completed (Total)**	40	(100)	71	(100)	111	(100)
Five Days or Less	0	(0)	2	(3)	2	(2)
Six to Ten Days	6	(15)	10	(14)	16	(14)
Eleven Days or More	28	(70)	50	(70)	78	(70)
Information or Case Remained at Family Center	6	(15)	9	(13)	15	(14)
Number of Contacts made during Intake Process (Total)***	40	(100)	71	(100)	111	(100)
No Contacts	0	(0)	5	(7)	5	(4)
One Contact	12	(30)	31	(44)	43	(39)
Two Contacts	14	(35)	22	(31)	36	(32)
Three Contacts	4	(10)	8	(11)	12	(11)
Four or More	10	(25)	5	(7)	15	(14)

* Although 111 intakes were completed, response time information is only available for 82 of these.

** The intake process was considered "completed" when the case was transferred to the Adams County Department of Social Services for ongoing services.

*** "Contacts" is defined as person to person contacts with the client or other individuals involved in the intake, which may include other family members, police, hospital personnel, etc. this does not include telephone contacts.

abuse cases were responded to in one day or less, and 94 percent were responded to in five days or less. During the second project year only 38 percent of the cases had a one day response time. However, 76 percent of the cases were responded to in five days or less (Refer to Tables 1 and 2).

Intake Process Time: Both years, the intake process time for most of the cases was eleven days or more. Intake process was defined as the time period between receiving the referral and the transfer of the case for ongoing treatment. During the first project year 43 percent of the intakes took eleven days or more, and during the second project year 70 percent of the intakes took eleven days or more (Refer to Tables 1 and 2).

An analysis of the number of hours spent on each intake shows an average of fifteen hours per intake.

Number of Client Contacts During Intake: Both years, the number of client contacts during intake varied depending on whether the case was an actual or potential abuse case. Client contact was defined as a personal contact with the client and not a telephone call. During the first project year, 50 percent of actual abuse intakes recorded three or more worker-client contacts, and during the second project year 35 percent recorded three or more contacts. On potential abuse cases, the first project year showed 33 percent having three or more contacts, and the second project year showed 17 percent with three or more contacts (Refer to Tables 1 and 2).

Parents' Perceptions at Intake

During the intake process, the social worker recorded the parents' perceptions in three areas: 1) perceptions of the injury or potentially abusive situation in the home, 2) perception of the abused child [illegible] child at risk, and 3) perception of the Family Center involvement. In attempting to determine general perceptions in these three areas, the social worker's responses were totaled, and a percentage was calculated which showed the most prevalent perceptions of both abusing and potentially abusing parents.

Parent's Perception of the Injury or Potentially Injurious Situation in the Home: The greatest difference in the perceptions of abusing and potentially abusing parents was in the denial of the abuse or potential for abuse. Only 15 percent of the abusing parents denied the abuse while 34 percent of the potentially abusing parents denied that the potential for abuse existed. Thirty-eight percent of the abusing parents saw the abuse as "acceptable discipline," and 34 percent of the parents, designated as potential abusers, saw their discipline of the child which was in question as "acceptable." A fairly high percentage of both abusing and potentially abusing parents expressed remorse over the situations they found themselves in with their children (47 percent of the abusing parents and 32 percent of the potentials). Refer to Table 3.

Parent's Perception of the Abused Child or Child at Risk: The majority of responses both from abusing and potentially abusing parents showed that these parents considered the designated child as a behavior problem (75 percent of abusing parents and 66 percent of the potential abusers). This statistic clearly demonstrated the need for behavior management concepts to be provided to these parents. Other perceptions of the child were as a medical problem (12 percent of abusing parents and 8 percent of potentials); and as an unwanted child (5 percent of abusers and 8 percent of potentials). Other negative perceptions of the child were recorded for 7 percent of abusers and 17 percent of potential abusers. Refer to Table 3.

TABLE 3

PARENTS' PERCEPTIONS AT INTAKE

(November, 1974 - December, 1976)

	Total Abuser Responses	Total Potential Abuser Responses
Parents' Perception of Injury or Potentially Injurious Situation or		
Acceptable Discipline	38%	34%
Denial of Abuse or Abuse Potential	15%	34%
Feelings of Remorse	47%	32%
	n = 100	n = 115
Parents' Perception of the Abused Child or Child At Risk		
Behavior Problem	75%	66%
Medical Problem	12%	8%
Unwanted Child	5%	8%
Other Negative Perceptions	7%	17%
	n = 73	n = 118
Parents' Attitudes Toward Family Center Involvement		
Cooperative	44%	42%
Angry	15%	7%
Passive	11%	19%
Seeking Help	17%	21%
Resisting Help	12%	10%
	n = 126	n = 218

Parent's Perceptions of Family Center Involvement: Surprisingly, almost half of the responses recorded for both abusers and potential abusers showed them to be cooperative with Family Center involvement at intake (44 percent of abusers and 42 percent of potentials). Only 15 percent of abusers and 7 percent of potential abusers were recorded as being angry at the intake. Eleven percent of the abusers and 19 percent of the potentials were recorded as passive over the intake process. Seventeen percent of the abusers actively sought help through the intake process, and 21 percent of the potentials sought help. Twelve percent of the abusers actively resisted help while 10 percent of the potentials were recorded in this category. Refer to Table 3.

Precipitating Crisis

These data record the social worker's assessment of the immediate family crisis which precipitated either the abuse or the situation which brought the family to the attention of the Family Center in the case of potential abuse intakes. The precipitating crisis for both abusers and potentials were markedly similar. The three situations most frequently recorded as precipitating crisis were: 1) marital discord (21 percent of abusers and 25 percent of potentials); 2) financial (22 percent of abusers and 21 percent of potentials); and 3) other (31 percent of abusers and 22 percent of potentials). The majority of crisis listed as "other" were related actions by the designated child. Refer to Table 4.

Abuse Dynamics

During the intake process, the social workers recorded abuse dynamics they assessed to be present in the family. The five dynamics they addressed were taken from the literature on abuse and included: 1) parent lonely/

TABLE 4

PRECIPITATING CRISES

(November, 1974 - December 1976)

Crises Recorded	Abuse Intakes	Potential Abuse Intakes
Employment	10%	12%
Custody	3%	2%
Marital Discord	21%	25%%
Financial	22%	21%
Medical	13%	18%
Other	31%	22%
	n = 114	n = 215

TABLE 5

ABUSE DYNAMICS RECORDED

(November, 1974 - December, 1976)

Dynamics Recorded	Abuse Intakes	Potential Abuse Intakes
Lonely/Isolated	23%	21%
Inappropriate expecttations of child	23%	21%
Problems with own parents	23%	27%
Abuse provoking attributes of child	20%	12%
Anxiety with an exagerated response	5%	7%
Other	8%	9%
	n = 167	n = 296

isolated; 2) inappropriate expectations of the child; 3) problems with own parents; 4) abuse provoking attributes of the child; and 5) anxiety with an exaggerated response.

The assessment of these dynamics at intake were markedly similar for both abusers and potentials except in one dynamic: abuse provoking attributes of the child. This dynamic comprised 20 percent of the abuser dynamics and only 12 percent of the potential abuser dynamics recorded. Three dynamics recorded for abusing parents appeared with the same frequency: lonely/isolated; inappropriate expectations of child; and problems with own parents were 23 percent each of total dynamics recorded. In looking at the dynamics recorded for potential abusers, the one recorded most frequently was "problems with own parents," which comprised 27 percent of total dynamics recorded for this group. Problems with own parents was recorded if the abusers or potential abusers indicated they, themselves, were subjected to physical abuse or extremely poor parenting as children. Refer to Table 5.

Special Data Collection

After the Family Center had been in operation one year, two pieces of special data began to be collected: data on category of abuser and on parent loss.

Category of Abuser

In the Family Center's community based program serving a county-wide population, the types of child abuse referrals ranged from potential to severe abuse, with the majority of actual abuse referrals being in the "mild" category. Because the term "child abuser" is a value ridden word, the Family Center staff developed categories of abusers in an effort to break down the general term, "child abuser," and looked at types of abusers and the different services they might need. The categories developed were based on work previously done by Fredrick Roth, M.S.W., Eau Claire County Department of Social Services, Eau Claire, Wisconsin. Categories developed by Roth were modified by Family Center staff to include:

	Category of Abuser	Services Needed
1.	Situational Abuser. This includes one time or infrequent abuse where the abuse incident or potential is precipitated by a crisis in the client's life, i.e., medical, employment, marital, or financial problems.	Referral to concrete services Couples counseling
2.	Acceptance of Strict Discipline. This includes persons who abuse as a function of their discipline of the child, and who believe this type of discipline is warranted and is the best way of handling the child's behavior problems. This type of abuse may range from mild to severe and recurrs.	Family Counseling Parent Groups Child Management Classes
3.	Abusive behavior due to lack of education on child rearing, nutrition, etc., or emotional immaturity. This includes persons who abuse because of their lack of knowledge of child growth and developemnt and could include such incidents as spanking an infant for crying or having a failure to thrive baby because of a lack of knowledge about proper	Lay Therapy Public Health Nurse or Nutritionist Homemaker Services Social Work Counseling in Groups

nutrition. The abuse in this category could range from mild to severe, and may be recurring.	
4. Abuse relating to emotional illness of caretaker. This category includes persons involved in premeditated abuse, scapegoating, sexual abuse, and persons who lack self-control. The abuse by these persons is generally severe and recurring.	Intensive Therapy Individually or in Groups

The category of abuser into which the client was placed was determined by the social worker completing the intake. Data collected on 53 actual and 84 potential abuse cases show the following:

1. The largest percentage of actual abusers fell into the "emotionally ill" category (32 percent). Only 9 percent of the potential abusers were placed in this category.
2. The largest percentage of potential abusers fell into the "situational abuse" category (45 percent). Twenty-three percent of the actual abusers fell into this category.
3. "The acceptance of strict discipline" category captured a fairly large percentage of actual abusers (28 percent) and less potential abusers (20 percent).
4. Abuse or potential for abuse due to lack of education was seen more among potential abusers (25 percent) than actual abusers (17 percent). Refer to Table 6.

Parent Loss

The Family Center began collecting this data after a year of operation in response to requests by the social work staff. The staff completing the intakes believed they were seeing a fairly high percentage of abusing and

TABLE 6

CATEGORY OF ABUSER

(October, 1975 -- December, 1976)

Categories	Abusers	Potential Abusers
Situational abuse	23%	45%
Acceptance of strict discipline	28%	20%
Behavior due to lack of education	17%	25%
Behavior relating to emotional illness of caretaker	32%	9%
	n = 53	n = 84

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potentially abusing parents who had experienced parent loss prior to the age of 18. Since parent loss could be a contributing factor in the development of poor parenting skills, the project began collecting this information in order to look at the incidence of parent loss in the intake population.

The results of fourteen months of data collection showed that 41 percent of the abusing population seen at intake and 43 percent of the potentially abusing population had experienced parent loss (mother or father) prior to the age of 18. This loss was due to such situations as death, divorce, separation and foster home placement or placement with relatives. Although this percent appears high, only reference to a control population would show whether or not it is significant.

Demographic Data

Demographic data for 330 intakes resulting in abuse or potential abuse case designations were collected for two complete project years, November, 1974, through October, 1976. In order to provide a complete picture, the population was grouped as follows:

- Abused Children
- Potentially Abused Children
- Abusers
- Potential Abusers
- Abusing Families
- Potentially Abusing Families
- Abusing Parents
- Potentially Abusing Parents

Data on Children

Intake services were provided to 453 children, with 37 percent being abused and 63 percent being "at risk" for abuse. The majority of children (61 percent) were five years of age or younger, and the male child was more at risk (55 percent were male) than the female.

The range of abuse in a community-based program such as this is well illustrated by the figures on severity of abuse. The majority of actual abuse cases seen at intake were mild abuse (53 percent). Fourteen percent were severe abuse, 14 percent were moderate abuse, 4 percent were failure to thrive, 10 percent were sexual abuse, and 5 percent were emotional abuse. A definition of the child abuse severity index developed by the authors of the initial grant proposal appears on the charts which follow.

Children considered to be "special status," such as foster and adopted children, stepchildren, premature or illegitimate children, comprised 16 percent of the child population. The largest percentage of these were stepchildren (47 percent). Ten percent of the total child population were considered to have "special problems," such as physical illness, handicapped, emotionally ill, retarded, or other problems.

Medical evaluations were performed on 96 percent of the children who were abused and 52 percent of the potentially abused children. The Family Center nurse performed the greatest number of these evaluations (36 percent) with private physicians performing the next greatest number (22 percent).

Over the two-year period, 11 percent of total children coming to the attention of the Family Center at intake were placed. Placements of abused children were primarily court ordered (64 percent) whereas placements of potentially abused children were primarily voluntary (70 percent). Of the abused children who were placed, the majority were placed directly into foster care (73 percent). The majority of potentially abused children were placed in the Family Center Crisis Nursery (76 percent).

Data on Abusers and Potential Abusers

A total of 366 adults who were identified as abusers or potential abusers were provided with intake services during the two years. This includes parents and parent substitutes as well as adults unrelated to the child.

The greatest percentage of the abusers and potential abusers were mothers (43 percent of actual and 59 percent of potential abusers); the second largest group were fathers (28 percent of abusers and 29 percent of potential abusers); followed by father substitutes (13 percent of abusers and 7 percent of potential abusers).

The overall sex breakdown shows a fairly even split for abusing adults (51 percent male and 49 percent female). The picture is quite different for potentially abusing adults which showed 39 percent to be male and 61 percent female. It is evident that although females may be more likely to be identified as potential abusers, in fact the actual abuse is as likely to be administered by the male as by the female.

A comparison by age shows the abusing adult to be generally older (63 percent were 26 years or older) than the potentially abusing adult (51 percent were 26 years or older).

Data on Families

A total of 330 families were referred to the Family Center as abusing or potentially abusing over a two-year period. The majority of these families (64 percent) were small, with only one or two children. In 30 percent of the families both parents were identified as abusers or potential abusers. In 15 percent of the families having two or more children, all children in the family were abused or considered to be in a potential abuse situation.

Data on Parents and Parent Substitutes

Since treatment services are generally provided to parents or parent substitutes who abuse, rather than to a relative or unrelated individual who may be abusing a child, data on parents and parent substitutes were analyzed separately in order to develop a picture of the families in which abuse occurs and families considered to have the potential for abuse. Data on 342 parents and parent substitutes were analyzed over the two-year period, and through this data similarities and differences between abusing and potentially abusing parents can be highlighted.

Some similarities are that the majority of both abusing and potentially abusing parents were married (70 percent of abusing and 67 percent of potentially abusing parents); the two groups had a comparable educational background (40 percent of both abusing and potentially abusing parents were high school graduates); and comparable unemployment rates (both groups had a 9 percent unemployment rate over the two-year period).

Differences can be seen in the occupational breakdown, with a greater percentage of abusing parents in professional, technical, and managerial occupations (15 percent) as compared to only 7 percent of potentially abusing parents in these occupations; and a greater percentage of abusing parents earning $10,000 per year or more (33 percent) as compared to 20 percent of potentially abusing parents in this income bracket. Differences can also be seen in the percent of public assistance recipients appearing within these groups. Only 16 percent of abusing parents were public assistance recipients as compared to 26 percent of potentially abusing parents.

Complete demographic data on the intake population appear in the following tables.

TABLE 7

DEMOGRAPHIC INFORMATION ON ABUSED/POTENTIALLY ABUSED CHILDREN (November, 1974 - October, 1976)

	ABUSED		POTENTIALLY ABUSED		TOTAL	
	#	%	#	%	#	%
Total Children	167	(37)	286	(63)	453	(100)
Abused						
Potential Abused						
SEX						
Male	90	(54)	159	(56)	249	(55)
Female	77	(46)	127	(44)	204	(45)
AGE						
2 Years and Under	43	(26)	111	(39)	154	(34)
3 to 5 Years	42	(25)	80	(28)	122	(27)
6 to 8 Years	37	(22)	49	(17)	86	(19)
9 to 11 Years	36	(21)	36	(12)	72	(16)
12 Years	9	(5)	10	(3)	19	(4)
ETHNIC GROUP						
White	128	(77)	226	(79)	354	(78)
Black	6	(3)	13	(4)	19	(4)
Chicano	22	(13)	29	(10)	51	(11)
Interracial	8	(5)	8	(3)	15	(3)
Other	2	(1)	3	(1)	6	(1)
Unknown	1	(.5)	7	(2)	8	(2)
POSITION IN FAMILY						
Only Child	39	(23)	56	(20)	95	(21)
Oldest Child	58	(35)	90	(31)	148	(33)
Middle Child	30	(18)	51	(18)	81	(18)
Youngest	40	(24)	89	(31)	129	(28)
SPECIAL STATUS (Total)	34	100	36	100	73	100
Foster Child	1	(3)	0	(0)	1	(1)
Adopted Child	3	(9)	2	(5)	5	(7)
Step Child	19	(56)	16	(44)	36	(49)
Premature	2	(6)	4	(11)	6	(8)
Illegitimate	3	(9)	10	(28)	13	(18)
Other	6	(17)	4	(11)	12	(16)
(Percent of Total Children)		(20)		(12)		(16)

TABLE 7 (cont'd)

	ABUSED CONT.		POTENTIALLY ABUSED CONT.		TOTAL CONT.	
	#	%	#	%	#	%
SPECIAL PROBLEMS (TOTAL)	25	(100)	20	(100)	45	(100)
Hyperactive	4	(16)	4	(20)	8	(18)
Physically Ill/Handicapped	8	(32)	9	(45)	17	(38)
Emotionally Ill	3	(12)	1	(5)	4	(9)
Retarded	5	(20)	0	(0)	5	(11)
Other Problems	5	(20)	6	(30)	11	(24)
(Percent of Total Children)		(15)		(7)		(10)
REPORTED INJURIES (TOTAL)*					167	(100)
Failure to Thrive					7	(4)
Severely Injured					23	(14)
Moderately Injured					24	(14)
Mildly Injured					88	(53)
Sexual Abuse					17	(10)
Emotional Abuse					8	(5)
(Percent of Total Children)						(37)
MEDICAL EVALUATIONS (TOTAL)	161	(100)	148	(100)	309	(100)
Family Center Nurse	52	(32)	59	(40)	111	(36)
Colorado General Hospital	26	(16)	16	(11)	42	(13)
Private Physician	31	(19)	38	(25)	69	(22)
Tri-County Health Dept.	14	(9)	19	(13)	33	(11)
Local Hospital	22	(14)	7	(5)	29	(9)
Other	16	(10)	9	(6)	25	(8)
(Percent of Total Children)		(96)		(52)		(68)
CHILDREN HOSPITALIZED					39	(9)

*Based on a medical examination, the social worker categorizes the abuse according to the Child Abuse Severity Index developed by Adams County Department of Social Services. The Severity Index is defined below:

Severely Injured:	Broken bones, head injuries, massive bruises and severe hematomas.
Moderately Injured:	Numerous bruises, a few severe bruises, burns covering small areas of the body and lacerations.
Mildly Injured:	Superficial, light bruises, few in number.
Sexual Abuse:	Children sexually molested by a family member.
Emotional Abuse:	Children severely scapegoated by their family, outwardly rejected, subjected to severe chronic verbal abuse.
Failure to Thrive:	A child fails to thrive within the household for other than medical reasons. Failure to thrive is diagnosed after child is hospitalized and fed a normal diet for age and shows a weight gain of 1½ ounces per day.

TABLE 7 (cont'd)

		ABUSED CONT.		POTENTIALLY ABUSED CONT.		TOTAL CONT.	
		#	%	#	%	#	%
PLACEMENTS (TOTAL)		33	100	17	100	50	100
STATUS:	Voluntary	12	(36)	12	(70)	24	(48)
	Court Ordered	21	(64)	5	(29)	26	(52)
TYPES.	Crisis Nursery	9	(27)	13	(76)	22	(44)
	Foster Care	24	(73)	4	(23)	28	(56)
(Percent of Total Children Placed)			(20)		(6)		(11)

TYPES OF PLACEMENTS	Placement Distribution At Intake		Placement Distribution Over Life of Project*	
	#	%	#	%
Own Home	38	(77.6)	41	(82.0)
Crisis Nursery	2	(4.1)	2	(4.1)
Own Home and Therapeutic Day Care	5	(10.2)	6	(12.0)
Therapeutic Foster Care	1	(2.0)	1	(2.0)
Regular Foster Care	3	(6.1)	6	(12.0)
Other	1	(Missing)	1	(2.0)

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* Since some of these children were in more than one placement or treatment over the course of the project, numbers total more than 50. Percentages are calculated on the total child population of 50.

TABLE 8

DEMOGRAPHIC INFORMATION ON ABUSERS/POTENTIAL ABUSERS (NOVEMBER, 1974 - OCTOBER, 1976)

	ABUSERS		POTENTIAL ABUSERS		TOTAL	
	#	%	#	%	#	%
TOTAL ABUSERS AND POTENTIAL ABUSERS	156	100	210	100	366	100
RELATIONSHIP TO CHILD						
Mother	67	(43)	124	(59)	191	(52)
Father	43	(28)	62	(29)	105	(29)
Relative	5	(3)	2	(1)	7	(2)
Day Care Mother	5	(3)	0	(0)	5	(1)
Other Unrelated	7	(4)	0	(0)	7	(2)
Mother Substitute	2	(1)	4	(2)	6	(2)
Father Substitute	21	(13)	14	(7)	35	(9)
Mother's Boyfriend	6	(4)	4	(2)	10	(3)
SEX						
Male	79	(51)	83	(39)	162	(44)
Female	77	(49)	127	(60)	204	(56)
AGE						
19 and Under	11	(7)	17	(8)	28	(8)
20 to 25	46	(29)	86	(41)	132	(36)
26 to 30	49	(31)	59	(28)	108	(29)
31 to 40	34	(22)	31	(15)	65	(18)
41 and Over	14	(9)	16	(7.6)	30	(8)
Unknown	2	(1)	1	(.4)	3	(1)

TABLE 9

DEMOGRAPHIC INFORMATION ON ABUSING/POTENTIALLY ABUSING FAMILIES (November, 1974 - Ocober, 1976)

	ABUSING		POTENTIAL ABUSING		TOTAL	
	#	%	#	%	#	%
TOTAL FAMILIES REFERRED	145	(100)	185	(100)	330	(100)
NUMBER OF FAMILIES IN WHICH BOTH PARENTS ARE ABUSERS/ POTENTIAL ABUSERS					30	(9)
FAMILY SIZE						
One Child	34	(23)	52	(28)	86	(26)
Two Children	58	(40)	66	(36)	124	(38)
Three Children	32	(22)	38	(29)	70	(21)
Four Children	14	(10)	17	(9)	31	(9)
Five Children	3	(2)	8	(4)	11	(3)
Over Five Children	4	(3)	4	(2)	8	(2)
NUMBER OF FAMILIES IN WHICH ALL CHILDREN WERE ABUSED/ POTENTIALLY ABUSED	44	(30)	90	(49)	134	(41)

TABLE 10

DEMOGRAPHIC INFORMATION ON PARENTS AND PARENT SUBSTITUTES WHO WERE ABUSERS/POTENTIAL ABUSERS (November, 1974 - October, 1976)

	ABUSING PARENTS		POTENTIAL ABUSING PARENTS		YEAR TOTAL	
	#	%	#	%	#	%
TOTAL PARENTS	136	(100)	206	(100)	342	(100)
MARITAL STATUS						
Married	95	(70)	138	(67)	233	(68)
Divorced	17	(12)	29	(14)	46	(13)
Paramour	10	(7)	5	(2)	15	(4)
Separated	10	(7)	23	(11)	33	(10)
Unmarried	1	(1)	9	(4)	10	(3)
Other	3	(2)	2	(1)	5	(1)
INTERRACIAL MARRIAGES/ ALLIANCES	8	(6)	3	(1)	11	(3)
EMPLOYMENT STATUS						
Employed	80	(84)	92	(80)	172	(82)
Unemployment Rate*	9	(9)	10	(9)	19	(9)
Unknown	6	(6)	13	(11)	19	(9)
OCCUPATION						
Housewife	41	(30)	91	(44)	132	(38)
Professional/Technical/ Managerial	21	(15)	15	(7)	36	(10)
Unskilled/Para-professional	64	(47)	83	(40)	147	(43)
Clerical	2	(1)	8	(4)	10	(3)
Unknown	8	(6)	9	(4)	17	(5)

* To determine the unemployment rate, the number of mothers classified as housewives was subtracted from the "Not Employed" category, since they would not be considered in the labor force (working or seeking work).

TABLE 10 (cont'd)

	ABUSING PARENTS CONT.		POTENTIALLY ABUSING PARENTS CONT.		YEAR TOTAL CONT.	
	#	%	#	%	#	%
EDUCATION	136	(100)	206	(100)	342	(100)
High School Dropout	61	(45)	93	(45)	154	(45)
High School Graduate	55	(40)	83	(40)	138	(40)
College Graduate	2	(1)	6	(3)	8	(2)
Unknown	18	(13)	24	(12)	42	(12)
INCOME LEVEL						
$4500 or less	30	(22)	73	(35)	103	(30)
$4501 to $9999	48	(35)	81	(39)	129	(38)
$10,000 to $15,000	42	(31)	39	(19)	81	(24)
$15,001 to above	3	(2)	3	(1)	6	(2)
Unknown	13	(9)	10	(5)	23	(7)
PUBLIC ASSISTANCE RECIPIENTS	22	(16)	54	(26)	76	(22)
HISTORY WITH ADAMS COUNTY DEPARTMENT OF SOCIAL SERVICES						
No Case on Record	92	(68)	111	(54)	203	(59)
Case Closed	23	(17)	31	(15)	54	(16)
Case Opened	21	(15)	64	(31)	85	(25)

Part II

Chapter Four

ROLE OF THE NURSE ON A CHILD ABUSE TEAM

Mark Grassman, Dorothy Montoya
and Susan Pass

Introduction

The role of the nurse was conceptualized broadly by the Family Center Project. It was not limited to medical evaluations of children coming into project services. It also included viewing the nurse as a community liaison person who was identified as having specialized knowledge regarding the medical needs of abused children. In addition, the nurse educated the medical community about their responsibilities toward these children. Thus, the nurse on the Family Center Project had a dual responsibility: (1) to develop the role and contributions of a nurse in the department of social services and protective service system; and (2) to develop the role of the nurse on a child abuse team in the community.

Development of the Nurse's Role

The goal of having a nurse on the project was to demonstrate how specific nursing skills could augment the services offered to children and their parents by the project social workers.

Initially, the role of the nurse was conceptualized as: assisting the social worker during intakes, contacting initial sources of medical information and providing ongoing medical evaluation and treatment, and being a member of the Multidisciplinary Review Team. As the project continued, the nurse provided training, consultation, supervision and some treatment in cases of failure to thrive.

Assisting the Social Worker at Intakes

The nurse was present for the purpose of assessing the physical and emotional growth of the children and their families. The nurse approached the family with the non-threatening attitude of needing information about the injury or the family. Most parents allowed the nurse to do the Denver Developmental Screening Test on their child under six years during the intake process. During this initial contact many parents were nervous, remorseful, and open to some direction from the nurse. Thus, education about the abuse problem was begun during intake. A discussion of the vulnerability of the child to physical injury was conducted, including a discussion of head injuries, the danger of grabbing and twisting extremities, and the results of other violent acts. A matter-of-fact, nonpunitive, non-accusatory style was used, and most parents appeared to be involved in the discussion.

The nurse used techniques of observation, inspection, auscultation, palpation and percussion. The nurse was able to discriminate between normal and abnormal physical findings and evaluate which findings needed consultation or referral to other services. At intake, needed services were discussed and parents were offered guidance in the use of resources available in the community. Of particular importance to these children was an assessment of their immunization status and a referral to start a complete series. In some cases, assistance to the family around managing congenital or chronic health problems, e.g. heart problems, epilepsy or diabetes, was given to the family. Evaluating for the presence of significant emotional disturbances and psycho-educational problems was done. Contacts during and after intake with the family included advising and counseling parents regarding the child's illnesses, growth, discipline, development and remediation of behavioral problems.

During the intake process, the nurse and social worker were able to compliment each other and the dual services were essential.

Consultation

Consultation was given to day care centers, Head Start facilities, foster and day care homes, and the Crisis Nursery in order to provide information about medical aspects of child abuse, normal growth and development, and health care.

It was extremely useful to the Crisis Nursery, and foster and day care homes to have the services of a nurse available for recognizing and managing common childhood illnesses, taking throat cultures and calling results to the physicians for treatment recommendations. The management of self-limiting illness and minor accidents to the children was done by the nurse in the Crisie Nursery.

Consultation to social workers, school personnel, and nurse health aides occurred around the consistency of explanation for injuries received by the child, and the appropriateness of parent's expectations for their children of different ages.

Doctor's offices were offered advice on reporting procedures and given feedback as to what happened to the children and their families.

The nurse was very involved in testifying in court on behalf of injured children and/or their parents.

Training and Inservicing

Training was given by the nurse to the local hospitals regarding reporting procedures and the availability of services in the community. Many clinics held inservice training sessions, and physicians were also trained either in person or by telephone. Religious groups, parents groups, and other lay groups were also addressed by the nurse.

Treatment of Failure to Thrive

Three families were followed with bi-weekly visits. The initial evaluation included a history; physical examination including height, weight, and head circumference developmental examination for social skills, motor skills, languag skills and the Denver Developmental Screening Test; observation of maternal infa attachment and verbal or nonverbal expectations; inventory of environmental stimulation; record of child's sleep pattern and play activity; and an index of life change events for parents was used.

During the treatment periods, the nurse was available to assist the mother in improving mothering skills, gaining knowledge about her child's growth and development, and understanding the importance of adequate daily caloric intake. The mother became involved in establishing priorities for herself and the child. Visits were focused on the child's progress; the mother's strength and assets; following through with an adequate feeding pattern; learning her child's needs; helping the mother praise for good behavior, and assisting her in being consistent in her response to her child's needs.

Supervision

The nurse also provided supervision to five bachelor's level student nurses for three months at a time for field experience in child abuse. The medical supervision of the project nurse was provided by the chief nurse at the East Adams Office of the Tri-County Public Health Program. This support and guidance was very beneficial to the development and implementation of the role and responsibilities of the nurse.

Effect of the Dual Evaluation by the Social Worker and Nurse

The effect of the dual evaluation by a social worker and nurse during child abuse intakes proved to be very positive in terms of providing medical expertise education about child growth and development, and another perspective on the family. This was true for the social worker, the children and their families. Because the dual evaluation added new expertise at the time of the intake evaluation, the social worker could concentrate on an assessment of the family. This proved to be very beneficial in situations where a crisis was recurring and the home atmosphere was chaotic. The worker did not have to wait for a medical opinion about a questionable injury. If questions of a medical nature, e.g., medication arose, the nurse provided immediate information. Later, when a physician needed to be consulted about an injury or illness, the nurse could interpret difficult medical terminology to the worker and the Multidisciplinary Review Team.

For parents, the nurse's medical expertise meant they could obtain a medical opinion immediately about their child's injury. If they were trying to disguise their child's injury, they would experience more difficulty faced with the nurse's training and knowledge. The parents could also receive recommendations about appropriate medical treatment for an injury or illness.

The nurse also provided a very special impact to social workers and families as far as her knowledge about child growth and development was concerned. She gave accurate information to the social workers about whether children's growth and development was consistent with their parents' expectations. Her testing of children's growth and developmental levels added factual information to the social worker's assessment of the family, and increased the social worker's knowledge about these areas.

The nurse's knowledge about child growth and development proved invaluable for parents. They often asked her questions about physical and emotional problems that their children were experiencing. They sought her advice about how to guide their children through difficult developmental tasks, such as toilet training. They welcomed her advice about new and appropriate ways to discipline their children.

The final area in which the dual evaluation proved effective was to provide another perspective on the problem. To even an experienced social worker in the area of child abuse, the intake evaluation still presents situations where it is difficult to separate one's emotional reaction from the facts of a case. Having the nurse participate equally in the evaluation helped the social worker avoid assessments that might have been influenced by counter transference feelings. Sometimes the amount of information elicited at the intake evaluation was voluminous, and having two people listening often prevented any significant gaps of information.

The second point of view proved to be helpful to families. They appreciated the opportunity to speak with someone else if they felt that their explanations were being ignored. They also felt more important if they could talk with the nurse while their children or spouse talked with the social worker.

As a final note, the dual evaluation evolved into a mutually reinforcing relationship for both the social worker and the nurse. Besides sharing their expertise they also found it beneficial to work together in a close, supportive structure where ideas as well as feelings could be shared.

Outcome

Data collected from September, 1974 through January 1977 shows a total of 32 medical groups being addressed by the Family Center nurse and other project staff. A total of 1250 medical personnel including; nurses, doctors, mental health center staff, hospital staff, public health department staff and medical students were included in these presentation.

The nurse accompanied the social workers on approximately five intake evaluations each week and provided medical evaluations for an average of five crisis nursery children each month.

Chapter Five

MULTIDISCIPLINARY REVIEW TEAM

Mark Grassman, Mary Maroon,
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Introduction

The National Center for the Prevention and Treatment of Child Abuse and Neglect developed a model for team review for cases of child abuse and neglect. The authors of the initial Family Center grant proposal were familiar with this team and the benefits derived from it. In creating the program areas for the Family Center project, the authors conceptualized a Multidisciplinary Review Team to serve similar functions. As the committee of authors created this program component, they believed that such a team could be established immediately and that it would become a part of the project. Thus, the Adams County Multidisciplinary Review Team began functioning in February, 1974, seven months prior to the beginning of the project.

The Multidisciplinary Review Team was composed of representatives from various community agencies such as the Adams County Mental Health Center, Tri-County Public Health, juvenile probation, the district attorney's office, the social services department, and a protective service client.

When the Family Center staff began providing intake assessments for child abuse referrals several months later, the responsibility for chairing the team was transferred to the project director, and the Multidisciplinary Review Team began reviewing all of the project's child abuse intake assessments.

Much of the effort involved in establishing this team had been made prior to the establishment of the project. However, ongoing training and revisions in format continued over the life of the project. The Multidisciplinary Review Team had several objectives to guide it's activities and they were as follows:

1. To establish a Multidisciplinary Review Team consisting of representatives from medical, social services, legal, education, law enforcement, mental health and research;
2. To review each referral of child abuse and neglect received by the Family Center or the Adams County Department of Social Services staff;
3. To create necessary interagency communication to assure use of community resources;
4. To utilize data to guide public and community education efforts; and to
5. Write a Procedural Manual regarding coordination of countywide child abuse and neglect programs.

The Multidisciplinary Review Team had clearly delineated responsibilities which were extremely helpful to the continued functioning of the team. They were:

1. Team meetings scheduled weekly or biweekly, as necessary to assure the review objectives.
2. The project director was responsible for scheduling and informing team members of these meetings; preparing meeting agenda; assuring that adequate information was available regarding families to be discussed; having recommendations and other discussions which took place at such meetings recorded; assuring dissemination of such recommendations and information to appropriate individuals in the community; providing feedback to the team including results of suggestions and recommendations made previously; brought policy matters and program issues needing review to the attention of the

team; and writing a final version of the Procedures Manual.

3. The researcher of the project was responsible for: recommending policy and program alterations necessary to assure better accountability, research and evaluation systems for the project; providing the team with requested data, such as numbers, locations, socio-economic status, etc., of families in which child abuse has been reported to assist the team in arriving at policy and program decisions; and providing the team with data related to treatment of child abuse and neglect, such as resource utilization.

4. Each community agency and resource representative was responsible for providing his or her expertise in the review process; assuring communications regarding the project to and from his or her respective agency/program; and assisting the project director and members of the Family Center with policy and program issues effecting the adequate response to child abuse and neglect in the county, including public education, identification, diagnosis, disposition, treatment, and follow-up aspects of this project.

Over the life of the project approximately 1729 family referrals were discussed, and in the outcome section the disposition of these referrals and the types of recommendations are discussed.

Team Composition

There were changes in the composition of the team and individual agency representatives changed over time. This could have negatively affected the cohesiveness and functioning of the team, but it did not. The Adams County agencies had become so involved in the problems of child abuse that the agencies' administrators continued their commitment to team involvement. This was a significant contribution on their part, especially when several agencies were experiencing staff shortages and budget cuts.

During the first year of the project, funds were available to purchase the services of a pediatrician for membership on the team. Prior to that, a physician was not one of the team members. Because of the need for a medical assessment for all child abuse referrals the expertise of a physician was very helpful in assessing the health and injuries of the children discussed at the team meetings. The Multidisciplinary Review Team grew in their understanding of the need for a physician to assist the Family Center nurse in her health assessments. However, at the end of the project's first year, the team's pediatrician left the county. Simply by requesting a pediatrician from Tri-County Public Health Department, one became a member of the team.

Shortly after this experience, the team thought that lay representation from a consumer of protective services could be helpful in sensitizing the team, as well as in providing needed input regarding service delivery and resource development. The regional coordinator of Parents Anonymous became a member of the team to help fill the void of parental input.

During the project's last year of operation, two other representative groups joined the team. They were law enforcement and the public schools. Numerous attempts were made by project staff and the administration of the social service department to acquire law enforcement involvement in the team. The juvenile officers were an integral part of many child abuse evaluations. They would attend meetings to discuss individual cases but they resisted full participation. Part of the difficulty in acquiring their full participation was that Adams County has 13 law enforcement agencies, and not one officer thought he or she would have time to commit themselves to attend every week. However, as awareness and cooperation grew among social services, the Family Center, and law enforcement agencies, one of the juvenile officers volunteered to serve as a full-time member of the team.

Participation by school representatives on the team was developed in the last year of the project. Adams County has six large school districts and several smaller ones. The project staff attempted to involve school representatives as a part of the team during the second year, but school personnel did not think they could devote one afternoon a week to the team's work. However, when child abuse cases were discussed in which school personnel were involved with the family, those school teachers, social workers, or nurses would come to that team discussion.

During the third year of the project, letters were sent to the director of special services requesting their participation at a planning meeting regarding the team. As a result of this other effort to explain the need and contribution of school personnel on the team, participation was achieved. Because there were six districts involved and the feedback responsibility of the school representative was immense, two school people became members to share the responsibility. The plan which was developed and implemented was that every three months, two of the six districts would send representatives to the team.

Functioning of the Team

The Multidisciplinary Review Team met once a week to review all child abuse referrals, re-abuse, re-referrals, and cases that had been requested for team review. Initially the team would meet between two to four hours to review the cases every Thursday afternoon.

The Family Center and social services social workers would present written evaluations of the cases to be discussed. New referrals were usually presented within seven days to two weeks. These written evaluations consisted of the following categories of information:

- --Date of the team review
- --Date of receipt of the referral
- --School district
- --Severity index, type of case
- --Family name, children's names, birth dates, and address
- --Marital status
- --Information on referral
- --Social worker's evaluation
- --Medical history and description of the injury(ies)
- --Assessed strengths and limitations of the family
- --Case plan

During the team's first year, they requested that the social worker completing the intake evaluation be present for the team's review of their case. After more expertise was developed by the workers in their preparation of the written evaluations, the workers were no longer routinely asked to be at the team meetings. The project supervisor and the protective service supervisors presented their workers' cases. This alteration was much more efficient, and in most cases, the supervisor was very knowledgeable about the cases, thus assuring a thorough review.

The team viewed themselves as having three major responsibilities in regard to the cases. They were to review each referral evaluation for thoroughness, appropriateness, of the plan and related to systems issues.

The Multidisciplinary Review Team served a dual purpose in the intake process. First, it was a means of communications between systems, and second, it was a support system for all decisions. The supervisors were involved with the team to help educate other systems about the evaluation process and the limitations of workers.

The team offered a good process for a check and balance on the evaluation, as well as offering to share the responsibility of case plan decisions. For this reason, it was important that the material the worker wrote up for the team review be as thorough and complete as possible. The more complete the write-up the more helpful the team was to the worker and family.

One year after the project director assumed the leadership responsibility of the team, a training session was held. During that session the team altered the manner of reviewing case referrals. It was decided that a small team consisting of the project director, project nurse, the deputy district attorney, and the protective service supervisor liaison to the team, would review all referrals immediately prior to the regular team meeting.

The small team assumed the responsibility of assessing all case presentations for thoroughness. If any one member of the small team had a question regarding the case plan and/or if the evaluation were not thorough, the case was automatically reviewed by the large team. Other types of case presentations that were routinely reviewed by the large team were cases of re-abuse, sexual abuse, third party child abuse, re-referrals, and cases that the social worker or an agency representative requested be reviewed by the large team.

Another responsibility the team held in regard to cases was to either agree with the worker's plan, make recommendations, or to make suggestions to the social worker. As the project and department social worker's skills improved in presenting cases, they developed a case plan for the team's review. The case plan could range from identifying extensive services to closing a case at the end of the evaluation. The small team reviewed the case presentations, and if they agreed with the plan, the social worker was supported with a written acknowledgement of agreement. If the small and large teams did not agree with the case plan, written recommendations were given to the social worker. The social worker and supervisor were aware of the policy of the Adams County Department of Social Services to the effect that the team's recommendations were to be implemented. However, the supervisor and worker did have the option of re-discussing the case and negotiating with the team about their recommendation at the next team meeting.

As opposed to recommendations of the team which carried a department mandate, suggestions offered to the social workers were not mandated by the administration. They were offered in a sense of being helpful and as thoughts that might be further considered. Thus, the team attempted to be supportive of the worker's plan and also to provide information that may not have been considered by the social worker.

The third area of responsibility of the team was in the realm of systems issues. Case presentations occasionally indicated questions of agency communication breakdown, lack of prompt reporting, lack of cooperation, or lags in response time. These issues were responded to by the team and were identified as "systems" issues as opposed to "case" issues. The specific team member from the agency about which there was concern would offer a plan to attempt to resolve the issue and would advise the team of his/her effect at the next team meeting. Community systems not represented on the team, and for whom there was a concern, were systematically dealt with by the team chairperson or a small group of team members. The process of sharing responsibility for community system's approaches to the problems of child abuse and neglect proved very helpful.

Training

Prior to the beginning of the Family Center project, the team had been created through the social service department, and some training was provided to the initial team members. Basically, the training consisted of an orientation to the protective service system, dynamics of child abuse and neglect, and some training regarding treatment issues.

A short time after the project director assumed the responsibility of the team, roles and responsibilities of team members needed to be reviewed. During one training session the team members discussed their perception of the team's role in relation to the implementation of the Family Center Project. The consensus was that the team was a part of the project and they expected the project director to chair and organize the team meetings. They also agreed that the team would serve as a quasi-advisory group to the project. However, they did not view themselves as being mandated by the project's funding source.

Additional training sessions were conducted at three- to six-month intervals. The team would spend one half day meeting at a comfortable place away from telephones. During these sessions the team members discussed group process, content, and responsibilities. Agreements related to process and content were made and then implemented during the following team meetings. As legislation was enacted affecting the work of the team, training sessions were established to immediately alter procedures and allow for the team to be in compliance with the amended statute.

Training sessions usually occurred at other times than the regular weekly meetings. Team members attended the training sessions and appeared to perceive them as an integral part of their responsibility as a team member.

Issues

Team Development

When the Multidisciplinary Review Team was first created in Adams County, the team reviewed cases of child abuse on a selected basis. Workers or supervisors who wanted particularly difficult cases to be reviewed by the team presented them at the weekly meetings. The team's review was voluntary and not a policy for all abuse cases in Adams County.

However, when the project was implemented and project staff began providing all child abuse intakes in November, 1974, the policy changed. At that time every child abuse referral and re-abuse case was reviewed by the team. This change in the policy was initially difficult for social workers, who had related to the team in a different way. After many discussions by the social workers, team members, project staff, and the administration of the department of social services, the feelings of resentment were dispelled. The workers and the team arrived at a mutual understanding of expectations and roles, which alleviated much of the tension.

Impact on Team of Child Protection Act, 1975, and House Bill-1266.

In 1975, the Colorado State Assembly passed legislation concerning child abuse and neglect entitled the Child Protection Act of 1975. The impact of that legislation was that child protection teams were mandated in countries which received 50 or more reports of child abuse incidents in any one year. The child protection team was defined to be multidisciplinary, including representatives from the juvenile court, law enforcement, the county department of social services, the mental health clinic, the public school district, the lay community and minority population as well as a physician and an attorney. The result was a significant expansion of the Multidisciplinary Review Team from the original representatives which were to include medical, legal, education, law enforcement, mental health, social services, research, and the lay community. It also changed the nature of the team from a voluntary one to a team legally mandated to review evaluations of each report of child abuse and neglect. The team chairperson was also responsible to complete a follow-up report, including services offered and accepted and any recommendations of the team.

What was immediately evident was that it was not practical for the Adams County Multidisciplinary Review Team to review all neglect referrals, due to the numbers involved and the time commitment which would be necessary. The decision was made, therefore, to limit the review to reports of suspected child abuse and re-injury.

As the Child Protection Act outlined the duties of a team, they were primarily limited to reviewing the case plan. As an additional responsibility, the Adams County Multidisciplinary Review Team, assumed the function of dealing with the systems who were not responding to the reporting and investigation process.

In May, 1977, legislation was passed by the Colorado State Assembly which, along with other changes, amended the statutes to require meetings of the Child Protection Teams to be open to the public. This legislation was the result of an intensive campaign by a newspaperman in Denver who had sought court action to be permitted to attend the Denver County Child Protection Team meetings and was eventually barred from such meetings by a judicial decision. To date, no people besides the regular team members

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have attended the Multidisciplinary Review Team meetings in Adams County. After some initial concerns that this legislation would significantly change the team's operation, it now appears that the changes which are necessary need not interfere with the overall goals and operation of the Multidisciplinary Review Team. There is still concern about maintaining the confidentiality of the families reported, despite the provisions to protect that.

Use and Misuse of the Team

Throughout the team's existence, there have been occasional examples of the inappropriate use of the Multidisciplinary Review Team. One example of that occurred when a supervisor and social worker disagreed on a case plan, and the case was presented as a "request for review," with that disagreement not clearly identified as the issue. It was the consensus of the team that they were not properly an administrative review mechanism for inter-agency problems. It should be clearly stated that when such disagreement occurs between the supervisor and the social worker, both should be present for such discussion, and a prior agreement should be made as to what the team's role in this discussion should be.

Another example of the misuse of the team was an attempt to have the Multidisciplinary Review Team function in place of a supervisor. Specifically, social workers who brought cases to the Multidisciplinary Review Team when they had not completed their evaluations, at times appeared to be asking questions such as, "Where do I go from here?" With some unusual exceptions, it was believed by the team that it was inappropriate for the entire Multidisciplinary Review Team to spend the time and effort to accomplish tasks which were legitimately the function of the supervisor.

There were, however, times when the team had been utilized for review and discussion of issues aside from the review of case plans. Examples of these issues are a discussion of the responsibility of the Adams County Department of Social Services for the evaluation of referrals of pregnant women identified as high risk for abuse, and investigation of third party abuse. A discussion of such issues is entirely appropriate if the team is in agreement to discuss such matters and the purpose of such discussion is clear.

Diagnostic Versus Case Management Team

One issue that occurred during the project's relationship with the Multidisciplinary Review Team was the question of what the function of the Multidisciplinary Review Team was. Some Multidisciplinary Review Teams, such as the Child Protection Team at Colorado General Hospital, view their function as being primarily diagnostic, focusing on such factors as the medical diagnosis, the family dynamics, and the psychiatric evaluation of the individual parents. Their goal is to obtain a clear clinical picture of the family in order to assess whether the injury was non-accidental, the potential for further risk to the child and the specific treatment modalities that would be required. This approach emphasized more detailed accounts of the family's history, their interrelationships, the events that led to the abuse, and why the particular child was singled out for abuse. In many cases more than one person evaluated specific aspects of the family.

Although the Multidisciplinary Review Team in Adams County related to some of the above issues, they primarily saw their function as case and systems management. Basing their function on the philosophy that no one agency could provide all the services needed to an abusive family, they tended to focus their attention on the probability of abuse having occurred and then determining which service systems such as public health, mental health, schools, etc., could engage the family. More often than not, they emphasized a coordinated systems service approach rather than the clinical factors that led up to the abuse or the different therapy approaches that could be used.

Part of this approach was also to provide a check and balance for each of the systems involved with the family. This check and balance system served several functions including insuring that agencies provided the service they committed themselves to, allowing for increased input for decision-making on the family, decreasing overlap, decreasing the referral time lag, and decreasing the potential of the abusive family getting lost in the maze of agencies.

This systems management approach also allowed the team as a whole, rather than anyone individual, to be involved in resolving systems problems such as referral time lags or lack of cooperation of a particular system. This resulted in such decisions as asking the deputy district attorney to talk with a particular agency regarding the legal implications of child abuse referrals or recommending additional training in child abuse for a particular agency.

Finally, the systems represented on the team provided support to each other. The Multidisciplinary Review Team attempted to have an impact upon the children's service system by identifying needed services to children, encouraging the development of additional resources for children, and giving written and verbal support to agencies that were experiencing funding cuts in their children's program.

Both the diagnostic approach and the systems management approach serve vital functions; the systems approach because it coordinates services and decreases systems lags; and the diagnositc approach because it can give the social worker a more in-depth clinical picture of what he/she is facing. However, with the number of cases that most Multidisciplinary Review Teams in social service systems are mandated to review in Colorado, it is highly improbable that they could function as a diagnositc team. Therefore, it might be productive to consider a second, smaller team consisting of people specialized in certain clinical areas such as a psychiatrist, child psychologist, medical person, family social worker, etc., who would be available for a more in-depth clinical assessment of some of the particularly difficult abuse cases.

Outcomes

Statistics on Family Center and Adams County Department of Social Services' cases presented to the Adams County Multidisciplinary Review Team were kept for a total period of two years, seven months. This time period represents the length of time this team was chaired by the Family Center Director.

Table 1 on the following page shows the yearly increase in total number of cases presented, average number presented each month, as well as a substantial increase in average number opened for services per month over the two year, seven month period. The rise in the average number of cases presented each month--from 39 per month between November, 1974, and October, 1975; to 55 per month between November, 1975, and October, 1976; to 89 per month between November, 1976, and May, 1977--can be partially attributed to the fact that in April, 1976, the Multidisciplinary Review Team was required by Colorado State Law to begin reviewing all reported incidents of adolescent

TABLE 1

MULTIDISCIPLINARY REVIEW TEAM
SUMMARY STATISTICS
(November, 1974 - May, 1977)

	Nov., 1974 - Oct., 1975		Nov., 1975 - Oct., 1976		Nov., 1976 - May, 197	
	#	%	#	%	#	%
Total Intakes Presented (average number presented per month)	469 (39)	100	659 (55)	100	601 (89)	100
Cases Opened for Protective Services (average number opened per month)	356 (30)	76	471 (39)	71	417 (59)	76
Cases Closed (average number closed per month)	95 (8)	20	120 (10)	18	91 (13)	20
Cases Transferred to Others DSS Unit for Services or to other county department of social services (average number transferred per month)	18 (1.5)	4	68 (6)	10	39 (5)	4

These numbers represent cases transferred out of protective services units or adolescent units to units providing other services such as adoption, homemaking, day care only, or AFDC, as well as cases transferred outside the county.

abuse, as well as abuse of children 12 years old and younger.

Over the two year, seven month period, the extent of the Multidisciplinary Review Team's input into the case plans also changed. When social workers first began presenting their intakes before the Multidisciplinary Review Team, the type and quality of the information presented varied substantially. As a result, the Multidisciplinary Review Team made specific recommendations on practically every case presented.

This standardization of reporting data had an impact upon the type of input made by the Multidisciplinary Review Team. An analysis of 358 cases reviewed by the Multidisciplinary Review Team between February, 1977, and May, 1977, shows that for 55 percent of the cases reviewed, the Multidisciplinary Review Team agreed with the case plan presented by the social worker and made no other recommendations. For 21 percent of the cases, the Multidisciplinary Review Team agreed with the case plan as well as making additional recommendations; and in only 19 percent of the cases the Multidisciplinary Review Team did not agree with the plan and made alternative recommendations. (Refer to Table 2.)

Responsibility for Child Abuse Shared with Other Parts of the Community

Although a cooperative spirit existed in the Adams County community prior to the existence of the Multidisciplinary Review Team and the Family Center project, human service agencies working in the same geographic area often assume a narrow definition of their responsibilities. The Multidisciplinary Review Team has been instrumental in preventing these types of problems in the Adams County community. The interdisciplinary nature inherent in the Multidisciplinary Review Team has had a great impact on reinforcing the view of child abuse as a shared community problem, and the need to work

TABLE 2

MULTIDISCIPLINARY REVIEW TEAM

INPUT INTO CASE PLAN

(February 1977 - May 1977)

Total Cases - 358		
Multidisciplinary Review Team agreed with plan presented by social worker and had no other recommendations	197	55%
Multidisciplinary Review Team agreed with plan and provided additional recommendations	74	21%
Multidisciplinary Review Team did not agree with plan and provided alternative recommendations	70	19%
Other (no notations)	17	5%

together in confronting the problem.

The Multidisciplinary Review Team has helped dispel the notion that child abuse is solely a law enforcement or protective service problem. This type of legalistic approach often undermines the sense of shared responsibility which is essential for successful intervention with a social problem such as child abuse. If a family does have an abuse problem, the symptoms are often manifested in a variety of ways: poor physical or mental health of adults and children, delinquency, marital problems, poor school performance, and problematic behavior of children. These types of problems often warrant the intervention of several agencies. The degree to which the involved agencies work together will often reflect the degree of success in helping the family. The Multidisciplinary Review Team has served as a forum for information sharing and open communication, enabling problematic systems issues to be dealt with immediately. In such an environment, the protection of children and the helping of families becomes a more manageable task.

Adaptability

Transition of Leadership

The Multidisciplinary Review Team will continue to provide input into cases and systems issues in Adams County. The chairperson responsibility has been assumed by a protective services supervisor from the grantee agency. All of the agencies originally involved with the creation of the team and other representatives who joined later are continuing to serve on the team. Each member and his/her respective agencies have committed themselves to the team's effort on behalf of abusive families.

New Legislation

Several months prior to the end of the project the Colorado State Assembly passed legislation that required open, public team meetings. The legislation was of great concern to the Adams County team because of the potential liabilities to families. However, procedures and policies have been established by the team that allow for open and executive closed sessions. These procedures are in compliance with the law and do not seem to allow for violation of families' rights to confidentiality.

Utilization and Consultation to Other Countries

The project director has been providing consultation to other countries which are developing child protection teams. Over the three years of the project much has been learned through the team. Specifically, consultation regarding the team membership, functioning, training, worker's written presentations, resolution of systems issues, and adaption of new procedures resulting from new legislation has been requested.

Chapter Six

TREATMENT OF ADULTS

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Introduction

In the field of child abuse, the treatment of the abusive parents is a relatively new and expanding field of knowledge. The personality structure, psychopathology, and motivational factors present in abusive adults form a composite which constitutes a rather new phenomenon in the field of human services.

The Family Center Project had two identified goals related to the treatment of adults: 1) to make available a variety of treatment modes to the abusive parent; and 2) to determine the effectiveness of these various treatments.

To facilitate the achievement of these goals, the project staff used the following objectives in their treatment planning: 1) stopping the abusive behavior; 2) increasing the parents' self-esteem; 3) improving the parents' ability to make and sustain an emotionally mature relationship; 4) improving the parent-child interactions; 5) increasing the use of support systems; 6) increasing the parents' awareness of their own needs; and 7) increasing awareness of their children's physical and emotional needs.

Clinical Profile of Adult Population

Two instruments were given to adults who received treatment--the Self-Esteem Questionnaire and the Marital Questionnaire. (Refer to Appendices IV and V.)

Forty-seven adults were given the Self-Esteem Questionnaire. When compared to the self-esteem scores of 800 normal adults, their scores were significantly lower. In the normal population, self-esteem typically increases with age. However, in the Family Center caseload population, the self-esteem scores of the parents were most similar to those of elementary school children, the lowest scoring group. Thus, the parents in the Family Center caseload had measurable self-esteem problems at the beginning of treatment.

On the Self-Esteem Questionnaire, there is a scale which measures how satisfied people are with their feelings about themselves. Most people with self-esteem problems indicate that they are unhappy with their low self-esteem. However, the caseload sample indicated that they were satisfied with their lack of self-esteem. This unusual finding indicated either that these parents were denying unhappiness about their low feelings of self-worth or that they had accepted such feelings as their lot in life and had given up thinking about changing the feelings.

As far as their attitudes about their marriage were concerned, the 48 adults who completed the marital questionnaire early in the diagnostic process indicated satisfaction levels ranging from "very unsatisfied" to "completely satisfied." The average score was on the positive side of neutral, with over half having a score above "somewhat satisfied." Only three people used the rating "very unsatisfied" or "fairly unsatisfied." This positive view of the marriage at the time of entry into treatment was unexpected and may have represented denial. Likewise, the three factors of the questionnaire measuring goodness of couple communication, feelings that the spouse is a good person, and closeness to each other came out with the majority of the adults having very positive scores. At the time treatment began, only one or two couples appeared to be admitting to any significant marital problems in any of those areas measured.

This statistical representation of the abusive adult upon the beginning of treatment describes a somewhat different picture from that which the project social workers observed during their initial contacts with the client. The client population presented a low self-esteem and portrayed themselves as victims in their relationships with parents, spouses, or community agencies. They were willing to admit to unhappiness about their lives, providing they had some external source to blame for the problems. A possible explanation for such a discrepancy between the client's negative presentation of their lives during the interviews, and positive presentation of their lives in completing the questionnaire could be the defense mechanism of denial.

The questionnaires asked for personal feelings and reactions, and gave less of a chance for the client to focus blame on external causes or systems than did the interviews. In the absence of the chance to defend by externalizing, the clients may well have defended by denying feelings of dissatisfaction on the questionnaire answers. As trust develops between the social worker and client during treatment, it is possible that readministrations of any questionnaire given to the clients by their worker would result in a more accurate clinical picture.

Demographic and Treatment Data

Following is demographic information on thirty-six adults who comprised the Family Center caseload. Although this includes the majority of adults with whom the Family Center worked over the course of the project, it excludes those adults who were not part of the research population and for whom data was not collected. Of the 36 adults for whom data was collected, 35 received some form of treatment intervention.

Table 1

	Number	Percent
Total Adults	36	100%
Sex		
Male	19	52.8%
Female	17	47.2%
Marital Status		
Married	35	97.2%
Single	1	2.8%
Ethnicity		
Anglo	32	88.9%
Chicano	4	11.1%
Age		
Upper limit - 48 years		
Lower limit - 19 years		
Median age - 29 years		
Abuser Status		
Actual Abuser	8	22.2%
Not Abuser*	13	36.1%
Potential Abuser	15	41.7%
Severity of Abuse		
Severe	2	5.6%
Moderate	5	13.9%
Mild	7	19.4%
Sexual	2	5.6%
Potential	20	55.6%
Types of Treatments Received** (Total n=36)		
Individual Counseling	13	36.1%
Marital or Couples Counseling	20	55.6%
Family Therapy	10	27.8%
Group Therapy	4	11.1%
Child Growth and Development Classes	4	11.1%
None	3	8.3%
Parents whose children also received treatment	17	47.2%

Average Length of Time in Treatment by Modality	
Individual Counseling	10.7 Months
Marital or Couples Counseling	12.2 Months
Family Therapy	7.2 Months
Group Therapy	(Information not available)
Child Growth and Development Classes	1.8 Months

Length of Time on Caseload	Absolute Frequency	Adjusted Frequency
0-6 Months	4	12.9%
7-12 Months	8	25.8%
13-18 Months	10	32.3%
19-24 Months	7	22.6%
25-30 Months	2	6.5%
(Missing Data)	(5)	

Mean length of time on caseload - 11-12 Months

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*"Not Abuser" indicates that parent in treatment was not the actual abuser of diagnosed abuse, but that the spouse was.

**The total number of adults by treatment modality is greater than 36 because many parents were provided more than one.

Referral Sources and Case Selection Process

Even though the project functioned as a part of public social service department, the research design of the project dictated being somewhat selective regarding cases chosen for treatment. The essential, underlying criterion in all of the choices was whether or not the family was perceived to have some potential, however minimal, for willingness to engage in treatment.

The other criteria operative in choosing cases was related to the basic typology of the prospective case: potential abuse, a self-referral, sexual abuse, emotional abuse, failure-to-thrive, or actual physical abuse (for more detailed description of severity index refer to the Intake section). Cases of actual injury were either of a mild, moderate, or severe nature. The design was to experience as wide a range of abusive behaviors as possible within the various treatment caseloads in order to provide a diverse sample population for the research (Refer to Demographic Section).

In attempting to do this, the project's research differs from much of the other research done in the child abuse area which was, up until only a few years ago, almost entirely hospital based. The hospital-based approach to research has possibly introduced a process of natural selection which has weighted the sample population of abuse cases heavily in the direction of actual injuries, and in many cases, only the most serious of injuries. It was hoped that a community-based approach, drawing from a wider and more diverse sample population, would produce a more representative picture of the child abuse problem as a whole in Adams County.

The client population of the study was drawn from Adams County. The treatment cases were obtained directly from Family Center intakes or transferred from the Adams County Department of Social Service's intakes.

Making the Diagnosis

When making an initial assessment of an abusive adult client following the intake process, project social workers considered the standard diagnostic categories of motivation, capacity and opportunity. These areas were assessed in relationship to abusive dynamics.

Motivation

It was important to understand the type and amount of motivation for treatment. Court-ordered treatment often created a motivation that was rooted in fear, i.e., "What will happen to me if I do not accept a treatment plan?" In cases where the treatment was court ordered, there were other issues which interfered with the client's ability to be positively engaged in treatment. One common example was that abusive parents, in keeping with the abusive profile, need to please and to be the good child. The result of this dynamic was that the client tended to be engaged in treatment very superficially. They would avoid getting into negative transference feelings because it would threaten their role as the pleasing child. And in many cases, the clients were so angry and affronted by social services' involvement that a positive motivation level was nonexistent. To the contrary, they were strongly motivated to sabotage, rather than engage in, a treatment plan.

Capacity

Another factor to consider in making a diagnosis was the client's capacity to work in treatment. Many abusive client's capacity to change was limited to alleviating situational stress precipatated by financial, marital, or discipline problems. In some cases, however, the clients did demonstrate a capacity to make structural changes involving their low self-esteem, anger at their parents, and need to please adults. For such clients, long-term therapy was indicated.

Opportunity

The question of whether or not a client had the physical opportunity to engage in treatment presented a very realistic concern. Abusive adults characteristically are isolated within their community, and in some rural parts of Adams County, they were not part of any community. This presented logistical problems in terms of transportation, if the client had no car, and availability, if there were outreach services established in the area. Another logistical problem concerned the client's work schedule. Often they worked long hours and were unable to get time off during the day for a therapy appointment. These issues frequently interfered with the establishment of a positive treatment plan, despite a client's high motivation and capacity level.

Negative counter-transference sometimes hindered the social worker's ability to make an objective diagnostic evaluation, and it was necessary to seek supervision to avoid this potential interference. When first approaching the client it was important for the therapist to get emotionally beyond the abuse incident. He/she needed to move from the natural and understandable emotional reaction of viewing the client as an "abusive parent" to viewing him as a real person. It was important to view the client as a person with a life history who possessed strengths and weaknesses.

Development of the Treatment Plan

After an assessment was made of the client's level of functioning, ability to cope with stress, and willingness to work with the therapist in improving his life, the task at hand was to select a modality of treatment and formulate a treatment plan which would best meet the client and families' needs. In approaching this phase of treatment, several factors were taken into consideration:

1) which treatment modality might best serve this particular client or client system; 2) which treatment modality the therapist preferred; and 3) what types of treatment were available.

Treatment Modalities Available

The treatment modalities which were offered to adults were: individual, marital, family, and group therapy; lay therapy; and child growth and development groups. In addition, the project also made use of other community resources for the treatment of abusive parents such as Parents Anonymous, the mental health center, and the public health agency.

Various project staff were involved in offering each of the above treatment modalities. Sometimes clients were involved in more than one form of treatment during their contact with the project. There was no waiting list for any type of treatment.

Since the influence of the psychoanalytic model of therapy is the dominant one in the field of child abuse, individual, insight oriented psychotherapy was a major form of treatment offered. This choice of treatment basically derives from the belief that the abusive parent was himself the object of inadequate parental nurturing as a child. A major focus of this type of treatment was for the therapist to relate to the client in a manner more supportive than past significant others. The therapist provided a nonjudgmental, interpretive atmosphere in which the client could work through those inadequacies and losses experienced during childhood. This enabled the client to relate more adequately to his/her own child. The basic rationale for the choice of individual psychotherapy was that the abusiveness of the parent was viewed as a symptom of a deeper intrapsychic conflict or deficiency which was best worked through on a one-to-one basis.

Marital therapy was often the treatment of choice. Sometimes this was done in conjunction with individual therapy. It was selected if the abuse incident or general atmosphere of abusiveness was perceived by the parents as a symptom of a relationship or communication problem. Adults engaged in an unhealthy (e.g. hostile-dependent) relationship, or an unsatisfying relationship will often look to the children to meet needs that ideally should be met by the other partner.

In marital therapy the therapist helped the adults identify and work out problematic differences. The therapist sometimes acted as a negotiator or facilitator, even to the extent of helping the partners re-define their contract with each other. In some instances, the marital therapist assumed a supportive role when two adults who had already decided that their relationship with each other was not workable, made the decision to separate and/or divorce and worked on the often difficult decisions around custody.

The most frequent role of the marital therapist within the child abuse context, however, was to help the adults see how their dysfunctional relationship was having a deleterious effect on the children. This effect may have been taking the form of actual physical abusiveness, verbal abusiveness, or even the complete ignoring or withdrawal of affection and positive attention from the children, because they were so involved in their own problems.

The choice of family therapy in working with child abuse cases often derived from the conceptual notion that a problem does not just affect those persons immediately or directly involved, but rather has an impact on all members of the family. In fact, it was often the case that all family members had an investment in keeping the problem alive. In situations such as these, confrontation and involvement of all family members was essential and constituted the treatment of choice. However, this was not possible if there was no motivation present in the family to engage in family therapy.

In cases where only one child was being abused with everyone's tacit approval, or where one child was being continually scapegoated by all family members, a treatment approach which involved the entire family was the most efficient and effective means of resolving the problem. In other cases, the death of a family member, or the introduction into the family system of a new member such as a stepparent, might have generated feelings which never had been sufficiently discussed or resolved. Such unresolved situations were often manifested by abuse of one child, or by the existence of a general atmosphere of abusiveness which all members were a part of.

Group therapy, with the therapist assuming an active role, was utilized to a limited extent during the course of the project's existence. Group therapy following the self-help model, such as the Parents Anonymous organization, where the professional was present, but not actively involved, was used to a greater degree.

Group therapy has been effective with abusive parents who recognize in themselves inclinations to abusiveness, and a general lack of knowledge about children and parenting. These adults often possessed a degree of motivation which made it possible for them to share common feelings with others in the same situation, whereas staying in individual treatment required more motivation to engage in therapy.

The physical act of coming together to form a group also acts as a catalyst to move the clients out of their isolation and into contact with others. This alone was often helpful in beginning to break the abusive cycle. The openness about feelings of frustration with their children, or fears of what might happen if they lost control, coupled with the confrontation or empathetic feedback they got from other group members, was often instrumental in providing the impetus to change.

The group environment was helpful in providing needed support to parents who were attempting to come to grips with difficult self-realizations, or make painful decisions relating to their roles as parents. These might be feelings, such as having a great deal of anger at being married and having had children too soon in their life, or hatred of a parent who might have abused them as a child, and how they have been taking this anger out on their children. The group was also helpful to the person who was discovering that his abusiveness was due to the fact the he/she never wanted to be a parent, and thus was faced with the painful decision of whether or not to relinquish his/her child.

In situations such as these, the environment of the therapeutic group (including the confrontation and support which could best be found in a situation where one was relating to others sharing a common predicament) provided an excellent opportunity for parents to get insight into and change their abusiveness. They helped the adult move beyond the guilt for his abusive behavior to the point of making positive changes in his life.

While the analytic approach was much evident in how project staff viewed therapeutic modalities, the preferences of some therapists often encompassed different conceptual approaches to therapy. Some were of a more behavioral nature, others reflected a shift from a focus on intrapsychic conflict to a focus on the realization of personal potentials and an awareness of the individual's inner nature.

In whatever model the therapist used, the emphasis was upon helping the client's growth, particularly in the area of issues involved in abuse.

In the course of formulating a diagnosis and treatment plan for some individuals and families, it became apparent that therapy of any insight oriented type was not what was wanted or needed. In some cases, there was a need for intervention of a more educational nature. Such intervention dealt with child growth and development issues, appropriate forms of parental discipline, how to plan and implement an equitable distribution of household responsibilities, or how to develop more effective interpersonal problem-solving abilities. Whatever the issue, the focus was more on teaching skills or imparting information, rather than on facilitiating change through insight or behaviorally oriented treatment techniques.

Child Growth and Development Groups

As part of the treatment of adults, one of the project's services offered to parents were educational groups on child growth and development. The goals of these groups were to increase parents' knowledge of child growth and development, and to decrease their apprehension and enhance their confidence in their parenting role. In order to accomplish these goals, the project staff set two main objectives. First, they concentrated on presenting the basic concepts of human development, and second, they emphasized the interrelationship of physical and psycho-social development to the family system. From July, 1975, to June, 1977, approximately two hundred people participated in these groups. About one half of these were abusive parents referred by project staff and protective service workers. The other half were single parents under the age of twenty-two who were enrolled in an alternative education program in School District 14.

Implementation of the groups involved some basic assumptions about the participants, the referral system, the setting, and the curriculum. The participants in the groups were primarily abusive parents who had high expectations of their children and who felt very defensive about their parenting skills. Therefore, the group leaders decided to focus the sessions on normal child development and to keep the discussion informal. Initially, the project staff decided to obtain referrals from protective service caseloads; however, they soon realized that as a matter of prevention any parent could benefit from knowledge about child growth and development. Therefore, the project relaxed the referral criteria. In one instance they opened up the group to a rural community in the county as an adult education class. In another instance they integrated the group into an alternative educational program for single parents. Another important assumption with regard to the referral system was that the group leaders coordinated regularly with referral sources. This was done in order to keep nurses, teachers, and therapists aware of the parents' educational progress. The project staff felt that an outreach effort was necessary because of the immobility of some parents, and because of the fears abusive parents experienced about sharing their ideas and feelings. An educational group was offered in each municipality of the county, except for one. In the latter instance the project staff felt that there were not enough referrals to justify a separate group. Finally, in developing the curriculum, the staff emphasized the importance of both physical development and psycho-social development. The content of presentations was designed in this manner, and they stressed the importance of including both a social worker and a nurse as group leaders. (Refer to Appendix VI.)

During the two years that the groups existed, the major strength or innovation was the complementary values of child growth and development education in the total treatment plan for an abusive parent. The groups developed into a secure place for parents to share ideas as well as obtain support for their parenting role. They liked the informal atmosphere of the groups, where they did not experience high expectations and critical judgements. Another major strength of these groups was the support of the communities. In establishing groups in different communities, the staff was always enthusiastically welcomed with the use of existing facilities and resources.

If there was a limitation to the idea of child growth and development groups, it was the lack of participation. Despite active outreach and recruiting efforts, the number of participants still averaged less than six people per session. This was due in part to the parents' transportation and day care needs that could not be met. As mentioned before; however, the primary reason seems to be the resistance on the part of abusive parents to share their ideas and feelings in a group.

Adaptability

Before the project grant ended, the nurse and social worker who were leading the groups actively sought to integrate the responsibility for

for the group into the community. They formed two separate groups with a student social worker and a Tri-County nurse as co-leaders. When the project ended, the nurses at Tri-County Health and the social workers at the Adams County Department of Social Services were committed to organizing and leading similar parent education classes.

In summary, the project of the child growth and development groups should be formulated for the dual purpose of education and support, because abusive parents are threatened by highly structured group situations. Second, transportation and day care services would encourage a larger number of participants. In this regard, the use of student volunteers from local high schools could be considered. Third, the groups should be open to all parents, and they should be publicized to as large an extent as possible. Any parent can benefit from the knowledge of child growth and development, and a larger number of participants will help accomplish the goal of preventing child abuse. Fourth, the groups on the project grant were held for approximately ten sessions each. This was too demanding for most parents and, therefore, shorter time periods such as three to five sessions would possibly prove more effective. Fifth, all of the community resources should be utilized to educate the parents such as speakers, films, and health publications.

Major Themes

In order to give an idea of the issues focused on during the treatment process, the content has been divided into five major themes. One prevalent theme in working with abusive parents was their lack of self-esteem. Issues involving this theme included how the client saw himself in relation to significant offers in his environment. In general, most abusive parents tended to describe themselves in very negative terms. Sick, crazy, dumb,and stupid were among some of the descriptions used. Consequently, they tended to expect others in their environment to relate to them in such a way that would reinforce these self-descriptions. Initially, the abusive parents were very reluctant to give up this negative identity. Because they rarely experienced themselves as "good, adequate, and healthy," giving up the negative self-image could be experienced as a loss of self-identity. Giving it up meant there was nothing to replace it.

The second major theme focused on during the treatment of the adult was the improvement of interpersonal relationships. Most abusive parents tended to have poor interpersonal relationships, whether with their families of origin, spouse, friends or children. In general, the abusive parent's problem in present relationships stemmed from unresolved conflicts with past significant others. The histories of the adults showed long years of physical abuse coupled with emotional unavailability of the parents. There was a vicious cycle of constantly looking toward the parent to get their needs met and most often being disappointed. There were times when they did get positive attention from the parent, but they soon learned that it was only when it benefitted the parents' needs. The abusive parent, as a child, came to understand that he was only an extension of the parent and not an individual in his own right with needs and feelings of his own. The inconsistency of either physical or emotional availability of the parent left the child with tremendous sensitivity to loss or change and extreme separation anxiety. This inconsistency often left the child with the inability to form healthy attachments to any one adult figure and often resulted in tremendous rage over the constant disappointments. Since the normal dependency needs for nurturing, affection, and security went unmet when they were children, the abusive adult looks to get these needs met in his present relationships. These tended to be a repetition of relationships with past significant others and could best be characterized as being hostile-dependent. On the one hand, the abusive parent tended to idealize certain significant people (parents, spouse, friends, therapist) and invest in them the power to meet all their needs, regardless of what these needs were. On the other hand, the abusive parent would either set up situations or choose people who would constantly disappoint them by not meeting their high expectations. The result of this continued disappointment was the recurrance of the uncontrollable rage which generally became directed either toward the child or the self. Because of the physical and emotional inconsistency of the family of origin, the abusive parent had never successfully been able to psychologically separate and individuate. This resulted in a termendous fear of getting too close or merging and an extreme sensitivity to separation or loss. The abusive parent, as a child, experienced at times being engulfed by his parent and losing even the shaky identity he had, and also experienced times when he feared the loss of the parent and was concerned he would no longer exist. This process is re-experienced in his present-day relationships. This process, in general, is behaviorally manifested by numerous separations and reconciliations, violent fights interspersed with times of clinging dependency, pulling towards and pushing away of the children, and erratic attendance at appointments with the therapist. The client will talk about the process during the hour in terms of being taken over or brainwashed, or possessed by the other person, and will also talk about his fears of being alone, not existing, feeling emptiness or nothingness, or being very anxious without being able to put words to the feelings or attaching the anxiety to any particular situation.

Another result of the lack of separation and individuation that is focused on in treatment is the abusive parent's inability to be aware of his own needs and separating them out from others needs. The abusive parent has been told in many ways that he does not have needs or feelings of his own. Very often, the abusive parent's feelings and needs were so confused or undifferentiated that he/she could not verbalize them. It was also very frightening to admit that they had needs, both because they feared being overwhelmed or overwhelming the therapist, and because it stirred up the numerous disappointments and deprivations of the past.

A fourth major theme of treatment was the improvement of the parent-child relationship. Many of the issues referred to in the discussion on interpersonal relationships relate to the type of interaction that went on between the abused child and the abusive parent. Two of the most common interactions were role reversal and the symbiotic nature of the relationship Like their parents, the abusive parent tended to see the child as an extension of himself without any differentiation of the needs and feelings. The abusive adult also expected the child to meet his needs and consequently put the child in the role of the longed for parent. When the child could not fulfill these functions, disappointment again occurred and resulted in rage and the lack of impulse control. An abusive incident would then usually occur.

Besides the lack of impulse control, these parents never had appropriate parenting models and, therefore, lack adequate parenting skills and the ability to problem solve and consider alternative modes of behavior. It is not uncommon to hear abusive parents complain that their child cannot control his crying, or his bowels, or his anger prior to the age appropriate time. Frequently, abusive parents will expect 2 and 3 year olds to clean house, make dinner and take care of younger siblings. Their concept of child rearing is not based on teaching the child how to survive and get what he needs from the world, but is synonymous with punishment and control. Discipline, to abusive parents, usually means physical punishment and rarely are other modes tried. The parent's own conflicts and lack of self-esteem must be dealt with before they are able to be aware of their child's needs and meet these needs in an appropriate fashion.

The final theme most often focused on with abusive parents was increasing the use of support systems. Abusive parents were extremely isolated. It was not uncommon for abusive parents to live in a neighborhood for many years and not know their neighbors. Few had any people that they called close friends. Some were even physically isolated because they had no car or telephone and they had no activities outside the home. Their lack of trust, lack of self-confidence and repeated failures and disappointments kept them from seeking outside support systems or activities which would better help them deal with both their physical and psychological needs. As they began to deal with the other issues outlined above, they were better able to risk getting involved with other people and activities outside the home.

Now that the themes have been identified the phases of treatment will be discussed.

Initial Interview

This material describes the treatment phases following the intake assessment, which is described in another section of this report.

The initial interview, whether it was with an individual, marital couple or family, was typically a time in which the client was the most hostile toward the intervening therapist. Diffuse anger stemming from unresolved intrapsychic problems, current crisis situation, extreme frustration and sometimes despair, and/or isolation was directed to the therapist. It was important that the therapist allow himself/herself to assume this arbitrary adversary role in order to facilitate this necessary ventilation process. The therapist needed to respond to this release of diffuse anger in a sympathetic, nondefensive manner. This attitude was conveyed when the therapist kept the focus off the abuse incident, thereby fostering the client's feelings of victimization from their own past and empathizing with their numerous life stresses.

It was necessary to do problem definition in the first interview. Some clients chose to describe their conflicts in terms of the presenting crisis situation. Others pursued the conflicts in more depth and began to share their past history with the therapist. Regardless of their degree of introspection, the therapist needed to begin at the client's level. Consequently, if a single parent mother needed to focus on her ex-husband's financial irresponsibility in paying child support, or if a family needed to scapegoat a younger child as the prime instigator of family disruption, the therapist listened attentively and empathetically to the client's need to place blame on another person.

It was extremely important in working with abusive clients, that the therapist demonstrated a quality of judgmental, empathetic understanding in the first interview. It was very difficult to establish a positive working alliance, if protection of the child was the main focus of the first contact. Clients sometimes viewed the therapist as an outsider, and someone who was invading their privacy and watching for futher signs of child abuse. Such a stance interfered with laying the foundation for a treatment alliance. In order for a treatment plan to be effective, the therapist underplayed his role as a child advocate, and focused on the needs of the parents.

Establishing an Alliance

The major difference between working with an individual or couple or a family involved the issue of transference. In a psychodynamic framework of individual therapy, the therapist allowed a transference to develop. Abusive parents tended to bring into the treatment relationship all the experiences and feelings they have had about significant others in their past. Because they have usually experienced these significant others as being very depriving, judgmental and abusive, they initially transferred to the therapist the negative feelings of the past and expected the therapist to be depriving, judgmental and abusive. It was, therefore, difficult at first to gain an alliance with the parent.

In the beginning phase of treatment, it was important to create an atmosphere in which the therapist responded to the client in a different way than he had experienced people's relating to him in the past. This was accomplished by initially allowing appropriate dependency, empathizing with the feelings and perceptions of the clients, encouraging them to talk about their fears, and beginning to help the clients understand that the therapist was a different person from past parenting figures. This was extremely difficult to do since the abusive parents tended to set up situations, either consciously or unconsciously, that would constantly test how the therapist would react.

In family and marital therapy, the therapist did not encourage the development of a transference between the client and therapist, but rather uncovered and defined the existing unresolved issues in operation between the family members. The role of the therapist became one of an active director, rather than a passive facilitator.

Aside from this apparent philosophical difference in approaching the issue of transference, the initial period of establishing a therapeutic alliance followed similar objectives in both family therapy and individual psychotherapy. Both treatment approaches focused on creating an appropriate dependency with the therapist, allowing the victimization cycle to be expressed, empathizing with their sense of inadequacy and their feelings of being overwhelmed without confronting their defenses. In addition, the therapist also assumed the role of an educator and information disseminator.

During the beginning phase of treatment these clients utilized their energy attempting to maintain their current functioning and, therefore, were often unable to direct their energy into developing alternative solutions to problems. As a result, they often demanded from the therapist specific answers to specific problems. Until some of the parents energy was released through resolution of some of the past conflicts, it was initially necessary for the therapist to gratify this need. If the therapist did assume a less directive role, the clients experienced this as a rejection and a frustration of their needs.

Another technique which spanned both individual and family therapy was the need for the therapist to lend his/her support to the clients. It was necessary to provide support until the clients developed the strength through treatment to grapple with their issues in a more independent and appropriate fashion. The family therapist, in particular, took a more directive role in the initial phase of treatment, and then withdrew as the family system developed internal strength.

Middle Phase of Treatment

Once the therapeutic alliance was solidly established with either an individual, marital group, or family system, treatment progressed to the middle phase. If an appropriate amount of nurturance and support were given in the beginning stage, the client-therapist relationship was secure enough to withstand confrontation towards a growth process. The major task of the therapist was to help the client explore new ways of coping, in order to interrupt the abusive cycle. This included heightening the client's awareness of his own needs and encouraging the client to meet these needs in a more adaptive manner. During this phase of treatment, the client's rage often surfaced.

At some point at the start of the middle phase of therapy, the client would learn that the therpaist was not depriving and abusive and would begin to idealize the therpaist. This idealization was also a remnant of a continuing past wish to have an all-powerful, all-knowing, and all-giving parental figure. Because of the lack of undividuation and separation, the idealized transference also allowed the client to defend himself against his rage by merging with the therapist and experiencing himself as omnipotent. At first, the therapist would encourage this idealization in an attempt to solidify the positive therapeutic alliance. During the course of the therapy however, usually something occurred that broke into the idealized transference. This could be anything from the therapist's misunderstanding of the client, or having to cancel an appointment, to using a word or phrase that the client perceived as being critical. When this occurred, the client again perceived it as a disappointment or frustration of his needs and experienced the therapist in the same way that he experienced frustration and disappointment from past significant others. This usually resulted in a tremendous amount of rage directed at the therapist. At this point it was important for the therapist to help the client identify his/her rage, and then help the client understand what the need was that the client felt was frustrated. In this way, the client was helped to understand what his deficits in development were, why these needs were never met, why they frustrated him now, and finally how he might be able to get those needs met as an adult in a more age-appropriate fashion. In general, the needs that abusive parents felt were unmet were needs for affection, nurturance, security, understanding, and esteem-building interactions.

Also during the idealized phase, clients often experienced themselves as helpless children. They again perceived the therapist as the all-powerful parent who could resolve any problem for them. This usually occurred when some external structure in the client's life changed, and the client felt as if he had no control over his life. The intervention of the therapist was then directed toward identifying, with the client, the helpless feelings, and helping him understand that they cam from a time in his childhood when he was a victim and had no control over his life. Furthermore, the client was helped to understand that he was now an adult and was capable of making the choices and decisions that would make his life feel more in control. This process took considerable time, and needed to be interpreted in many different ways to the client.

As a result of this increased self-awareness, the client was able to distinguish his own needs from his child's needs. This process was instrumental in intervening in the abusive parent-child interactional pattern. The therapeutic relationship helped validate the client as someone of worth with separate needs and separate ambitions. When the client experienced his/her growth process, tension was dissipated and the parent-child relationship was no longer constrained by unresolved feelings from the past.

In marital group and family therapy, the same issues of unresolved rage and distorted self-image became the major focus of treatment. The process differed from individual treatment, in that these feelings were not indirectly experienced with the therapist via a transference relationship, but rather directly experienced with the group or family members. The therapist's role was one of interpretation. He/she facilitated the expression of anger by tracking the symptomatic, repetitive patterns of interaction that took place between the members. He/she was instrumental in exposing and labeling the dysfunctional roles and rules by which the members operated. He/she actively set up situations in which members experienced each other in new ways, thereby allowing them to redefine more functional boundaries for their relationships. This process generated a more clear demarcation of parental and sibling roles, which alleviated the stress previously precipitated by diffuse parent-child boundaries.

Counter Transference Reactions

During this process the therapist also experienced many counter-transference feelings. Counter-transference feelings mean those myriad of feelings that the therapist experienced toward the client in the sessions. These feelings ranged from rage and frustration to helplessness and over-protectivenss. These feelings were highly diagnostic because they tended to mirror the feelings that the client was experiencing during the sessions. If the therapist was conscious of these feelings, they were used to help the client understand how he was feeling and what in the session or in his external life may have caused these feelings. They were also used to help the client see that what went on in the therapeutic relationship was often a repetition of what occurred in other significant relationships. For example, if the client were experiencing himself as the helpless child, he would usually elicit feelings of both helplessness and rage in the therapist. The therapist might also respond to this by feeling the need to be over-protective or rescue the client.

Because abusive parents were primitive in their emotional reactions, the feelings the therapist experienced were often very intense. If the therapist did not deal with what these feelings were, and where they came from, the therapist would repeat the negative interaction that the abusive parent had with others in the past. This would result in the therapist's coming across as judgmental, authoritarian, over-protective, uncaring or rejecting. It was usually at this time that an impasse occurred in the therapy. It was very important for the therapist to be aware of his feelings toward the client and how they related to the treatment with the client, so that these feelings were not acted out, but rather used diagnostically. This also points to the cruical need for ongoing supervision and consultation when working with the abusive parent. This will be discussed in another section.

Terminiation

During the termination phase of treatment the therapist encountered three important issues. First, he/she had to work through the termination of the therapeutic relationship and the treatment contract with the client. Second, the therapist had to be aware of and prepared to deal with counter-transference feelings. Third, he/she must be prepared to handle the unique administrative responsibilities in terminating a protective service case.

One of the most common issues that arose with abusive clients during the termination phase of treatment was their feelings of loss. Here the therapist had the opportunity to model a new kind of termination for his/her client. The therapist showed he/she was not rejecting the client by empathetically listening to the client's anger and sadness. As a result, the clients experienced a new process of termination in which they were encouraged to express feelings without an accompanying loss of self-esteem and realized that they had found a new way to cope with some of their feelings.

The rejection and low self-esteem surrounding the loss of a significant person could be overwhelming. In order to avoid their feelings they regressed to primitive defenses that were unsuccessful. Often clients were afraid to express their anger or sadness at the therapist for leaving. The fear was that the expression of such feelings would result in rejection. Instead of being angry or sad they acted out such feelings by missing appointments and, in some cases, a crisis such as re-abuse ocurred. In this instance the parent was so angry about termination he/she caused another crisis in order to keep the therapist engaged. It was important that the therapist interpret this behavior to the client by saying that it was all right to be angry, and by showing the client more constructive ways to express their feelings. The therapist needed to demonstrate that he/she would not retaliate when the client expresses his angry feelings. Clients exhibited these defenses as well as others during the termination phase of treatment. How they became aware of these issues and worked on them with the therapist offered an indication of their progress in therapy.

Coinciding with the sense of loss that a client felt at termination were feelings of satisfaction or despair in regard to accomplishing certain goals in the treatment contract. The amount of success felt by the client depended upon how realistically the goals were formulated and was dependent upon the experience of both awareness of needs and behavior change.

The second major issue of termination with abusive clients involved the therapist's ability to handle counter-transference feelings. Earlier in treatment the therapist used these feelings diagnostically and therapeutically. At termination he/she used these feelings to assist the client in focusing on how to end a significant relationship. For example, in a planned termination the therapist could experience overprotectiveness. He then needed to consider what this feeling meant in regard to his client. It may have been a situation where his client made progress in therapy, but was acting helpless and dependant in order to keep the therapist from leaving. Having recognized how his overprotectiveness related to the client's helpless dependent feelings, the therapist could then interpret this knowledge to his/her client. Using this termination process, the therapist avoided setting up a situation where the client experienced the termination in the same negative way that he had experienced losses in the past.

In unplanned terminations, therapists often felt guilty because they questioned the total effectiveness of their intervention. These feelings of guilt were particularly stressful in situations where the client left therapy and continued to have a strong potential for abuse. Counter-transference involved asking what this guilt meant to the client. It was likely that the client left therapy in these situations feeling helpless and angry, because the therapist continually frustrated his unhealthy behavior. Unfortunately, this knowledge did not help the client who left therapy prematurely, but it did help the therapist understand and prevent similar termination whenever possible.

The third issue during termination involved unique administrative responsibilities in closing a protective service case. When a social worker terminated treatment with a client in a protective service system, he/she must deal with other issues of an administrative or legal nature as well as treatment issues. If the termination were premature, in a case where the client refused treatment, the case might be left open and monitored because of the potential for reabuse. If a client left town without notice, the therapist needed to notify the court and the social services department of the forwarding address.

Supervision

Working in a child abuse program is difficult due to the nature of the client population; thus, supportive supervision is essential. Because of the need for more guidance and encouragement of the workers, the Family Center Project secured funding in its second year of operation for a supervisor position. Prior to the employment of that person, the Project Director was responsible for supervising all of the project staff. This was not adequate to meet the needs of staff, due to the director's other responsibilities.

The project social workers often dealt with clients who were hostile, and many of them had borderline personalities. Some of the stresses which needed to be discussed in supervision were the pressures of being readily available to extremely needy clients, and having to make potentially life-saving decisions. Additional stresses such as paper work, needing to attend meetings, and coordination efforts with other project staff increased the pressures on the social workers. Supervision around the issue of setting priorities in a job with many demands on a worker's time was clearly useful. The "burn out" rate for workers in protective services is very high across the country. Adequate supervision might well assist in relieving the pressures of this position.

Supervision of social workers in their treatment of abusive parents and children required knowledge of different modalities and therapeutic approaches. Project clinicians used individual, marital, and group therapy approaches. The supervisory approach used by the project supervisor was to provide support, encourage dialogue, and to attempt to provide stimulation for learning.

In child abuse cases, it is important for the supervisor to be currently carrying cases or to be experienced in the treatment of abuse so that he/she can use case material didactically. Workers can learn from using the supervisor's work as a model for dealing with problems in abuse treatment. When the inevitable difficulties arise in treating these families, being able to share problems and solutions is useful. It is extremely useful for the supervisor to be receiving ongoing supervision on his own casework, as well as his supervision.

Issues of counter-transference are very important in child abuse supervision. Abusive clients are especially needy and can easily cause feelings of guilt and frustration in workers. A need to take responsibility for the client can easily be engendered in the worker. Feelings of nurturant protective counter-transference for the child often arise. Asking the workers to be very specific about how they were feeling during interactions with these clients is an especially useful supervising technique.

A supervisor must override his/her supervisee in an abuse case, if he/she feels the child's life is in danger. Occasionally, a worker might be involved in his/her or the parent's transference issues and does not have an adequate plan to protect the child. If there is time, another opinion can be requested, either from the Multidisciplinary Review Team or another supervisor. If danger is immediate in the supervisor's view, he/she must override a worker's decision and do what seems in the best interest of the child.

To broaden the support base for the child abuse worker, peer and group supervision is very useful. Much informal peer supervision took place between project workers, who would use their peers as a support system. Also, the use of formal weekly sessions could be helpful as far as sharing in the learning process is concerned. Material shared can be case presentations as well as discussions of particular theories or ideas. The supervisor can act as a coordinator for these meetings, but all workers should be responsible for the presentation of material.

Outside consultants can be useful. If supervisees are encouraged to present material to all available resources, an atmosphere conducive to maximum growth is present.

The supervisory process, when geared towards producing growth, stimulating the worker, with the supervisor also learning from the interactions and dialogues is not only productive, but enjoyable. The supervisory process should be one that encourages positive self-esteem for all concerned, from the client to the supervisor.

Issues

During the life of the project, several issues arose in relation to the treatment of adults. The issues included the different theoretical beliefs of staff, the treatment contract with abusive parents, whether a client should come into the office for therapy, the difficulty of involving men in treatment, and court ordered versus voluntary treatment. Although the staff experienced these issues within a child welfare system, they could have arisen in other settings as well.

When people came together to work on this child abuse project, they brought with them more diversity then was readily apparent. They all shared a common goal in preventing and treating child abuse, however, their ways and means of accomplishing this varied. These different theoretical beliefs resulted in strengths as well as limitations in the course of treating abusive parents. The diversity was beneficial to clients, because an appropriate and realistic treatment plan was offered to them, that took into account their capacity and motivation for treatment. The diversity proved stimulating to the staff in the sense that they had the opportunity to examine and redefine their own values and beliefs. The fact that individual staff favored different treatment approaches also did not affect their committment to preventing and treating child abuse. On the other side of the picture, the diversity did prove difficult in two areas. First, the process of listening, understanding, and respecting another person's theoretical and conceptual framework proved to be stressful, when time did not allow for the accompanying feelings to be worked through. Second, the different treatment approaches made it difficult to develop a common theoretical concept that could be implemented as a detailed treatment approach for abusive parents.

The second major issue involved the treatment contract with an abusive parent. It was the belief among the project staff that general, verbal contracts were more effective than written contracts in obtaining an alliance with a client and changing behavior. They believed that specific written contracts set up clients for failure in a similar manner to the process that occurred when clients' parents set high expectations for them as children. This viewpoint differed from the philosophy of some community mental health centers which seem to favor specific written contracts with all clients.

The third issue addresses the question of whether a client should come into the office for therapy. Some of the staff provided therapy in client's homes because they felt comfortable in working in settings other than the office. They believed that requesting clients to receive therapy in the office added another expectation that would prove overwhelming to clients and set them up for failure. They also stressed the importance of respecting different cultural values that provided for an open-door policy of working either at the client's home or in the therapist's office. Other staff pointed out the value that home visits had in joining with the client in forming a positive alliance and in avoiding the creation of additional stress for the family. On the other side of the issue, staff argued against providing therapy in the client's homes because it fostered the process of having the therapist gratify all the client's needs. As mentioned earlier in the section on transference and counter-transference, if this idealized image of the therepist werenot worked through with the client, it set the therapist up to fail. Some staff also felt that asking a client to come into the office for therapy encouraged the client to assume appropriate adult responsibility.

The fourth treatment issue related to the difficulty of involving men in therapy. The research on this project indicated that more women were involved in treatment than men. Some of the reasons offered to explain this finding included: most single-parent families are managed by women, men refuse treatment because their role as head of the family is threatened, and more men are working than women. These explanations held some validity; however, a direct casual relationship was not found. The more critical question for project staff was to find ways to involve men in treatment, especially if they were the abusing parent.

The issue of court ordered treatment versus voluntary treatment continued to be a topic of discussion among the project staff. The main difference of opinion focused on the seemingly unresolved issue that ordering a person to seek treatment was directly contradictory to the therapeutic propositions of self-determination and self responsibility. Actually, there were valid points on each side of the issue. Court ordered treatment could be used effectively. to help some people motivate themselves, especially if they were used to being told what to do. Voluntary treatment seemed the optimal way to proceed in therapy in order for the client to internalize new attitudes resulting in behavior change. Regardless of whether treatment was court ordered or voluntary, the overriding fact was that children's rights needed to be protected, and the court was the only system that had the power to ultimately fulfill that responsibility.

LAY THERAPY

Sylvia Lane and Vicki Van Dyke

Introduction

As part of the Family Center project's basic goal to increase the effectiveness of treatment to abusive families, the establishment of a lay therapy program was planned. This concept was first developed in 1969, at the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado. They had discovered in their work with abusive families that the professionals were often unable to meet the enormous dependency needs of most parents in the time available to them. They decided to experiment with the use of lay people who could develop close relationships, spend several hours per week, and be available to abusive parents at times of crisis. Their evaluation showed positive results.

The purpose of including this program area in the project was to research and demonstrate its applicability to a protective service setting. The objectives of lay therapy were: 1) to prevent reabuse; 2) to shorten the length of treatment by the primary counselor by providing a more intensive program; 3) to promote more independent functioning of the parent by assisting in the development of more effective coping mechanisms; 4) to encourage the development of natural and ongoing support systems for clients; and 5) to provide an intimate and nurturing relationship which allowed for a more healthy expression of parent's emotional needs, and thereby prevented them from expecting their own children to meet their needs.

Implementation Tasks

The process of establishing a lay therapy program within a protective service agency was greatly enhanced by input from line staff and supervisors at Adams County Department of Social Services. This was accomplished through individual and group conferences. These conferences focused on the following: 1) limitations in the service delivery system for abusive parents; 2) tasks to be performed by lay therapists; 3) criteria for selection of cases; and 4) components of the training program. Consultation on these issues was also sought from representatives of community agencies. Lay therapy programs in other settings were also studied.

The advantages of input from line staff at the planning level were that: 1) practical considerations geared to a knowledge of the protective service system were included in the program; 2) more appropriate cases were referred to the lay therapy program; 3) an increased commitment to program goals was encouraged through administrative channels; and 4) improved communication with protective service personnel was achieved, which served to reinforce all of the above.

Although the advantages of input outweighed the disadvantages it should be noted that a strong involvement in planning tended to cause delays in program implementation; and at times resulted in communication issues between protective service workers and Family Center staff taking precedence over client treatment services.

Recruitment

A job description for lay therapists was developed with input from many people. The position was advertised through local newspapers and applicants were also referred by persons familiar with the program. As positions became available during the project's duration, the same process of recruitment was followed. Lay therapists sometimes recommended friends or acquaintances as applicants as the program progressed. Affirmative action guidelines were used in recruitment and hiring. The Family Center had a firm commitment to recruiting minority applicants.

It was important to find people who were comfortable being supportive and would not make unrealistic demands upon the parent because of their own needs to see someone else succeed. There are many people who function this way with their friends, neighbors or relatives; they are the "natural helpers" in the community. As the program became more visible in the community, these people were more readily identifiable.

Screening

Interviewing of applicants was conducted by a team, originally composed of Family Center staff and protective services workers. Lay therapists were included in the interview panel as vacancies occurred later in the program. Areas considered in the selection of lay therapists were:

1. The adequacy of the applicant's own parenting; how sound an emotional base the person had; had they received enough care and attention in their early years to be able to give some of this to another person at this stage? If their own early experiences and conditioning were negative, what things had they done to overcome this? Had they received help for this? Was it effective? What insights did they have into how their early life experiences were related to their desire to help abusive parents ?
2. Did they have the ability to give nurturance? Would they be comfortable in this role?
3. How adequate were their own coping mechanisms in handling personal problems?
4. Did they have a personal support system that was functional?

5. Could they separate the needs of the parents from the needs of the child?

6. What were their feelings about discipline? How should children be disciplined?

7. Could they work as a member of a team, or would they feel the need to be the sole advocate for the client? Were they open to group supervision?

8. Did they accept affiliation with the local social service department?

9. What were their stated feelings about child abuse and abusive families? Could they admit to having angry or unpleasant feelings? Did it appear that they were willing to look at feelings and how they affected what they might do with the families?

The experience of the project confirmed the opinion of the staff at the National Center for the Prevention and Treatment of Child Abuse and Neglect that it was important that lay therapists be parents themselves. Not only did this give the person the first-hand knowledge of the frustrations and difficulties of parents, but it also was an advantage initially with the parent who could not dismiss the lay therapist with the familiar complaint, "What does she know? She's never had any kids." It was also considered that the applicant's children be beyond infancy, as the responsibility of very young children severely limits the availability and flexibility of time. If an applicant was not a parent, at the very minimum they had to have had extensive experiences caring for children on a 24-hour basis.

Training

The basic skills used in lay therapy were not skills that an applicant could gain through training, but were skills learned through the lay therapist's own life experiences. Training, therefore, was geared toward orientation and improvement of existing skills, as well as an introduction to the dynamics of child abuse.

Training was also a time to introduce the lay therapists to the people and systems with whom they would be working. Involving Family Center staff, protective service workers and community people proved to be productive. In addition, the comments and suggestions that the lay therapists had about their training efforts were incorporated into later training sessions. As additional lay therapists were selected to fill vacancies, they were integrated into the weekly supervisory group meetings. This experience proved to be invaluable in their orientation and training. The topics or issues included in the training program were:

1. Basic information on child abuse: medical, emotional, and social factors which were pertinent to understanding the dynamics of child abuse.
2. Sensitivity training as related to abuse. This included understanding of the significance of the lay therapist's own style of discipline with his or her own family. They had to be sensitive to how they really felt about parents who physically injured their child. Discussion of this was allowed in a nonjudgmental atmosphere so that the lay therapist could adequately explore and deal with these feelings.
3. Information on legal issues related to child abuse. Lay therapists were trained and acquired a good understanding of the child abuse law for the state and what their responsibilities were as a private citizen as well as an agency representative.
4. Understanding the social service system and its various programs.
5. Practice and sharing time. The training program was on going and included time for discussion and sharing of issues regarding the families. It was important for the lay therapists to develop group cohesion which provided a mutual support system.

The training program was usually planned for a 2-3 week period with assignment of the first case following completion of that initial training. Follow-up training sessions and weekly group supervision followed.

Case Selection

The case selection process first involved the agency reaching a decision about the types of situations in which a lay therapist would be utilized. For example, there was a question about whether they would be used in actual and/or potential abuse situations; and whether they would be used in cases at intake or reserved for cases which had been in treatment for some period of time, and where some of the immediate crises had been resolved. Decisions were also made regarding the age, sex, and ethnic background of the lay therapist in consideration with the potential client.

In addition to those basic determinations, the following criteria were used.

1. Cases of severe emotional illness were screened out. It was felt that lay therapists should not be expected to handle situations resulting from potentially psychotic or dangerous behavior.
2. Cases were given priority where parents' unmet dependency needs were seen as a great souce of difficulty.
3. It was required that the parents be willing to accept a lay therapist.
4. It was required that the primary therapist for the family was willing to accept the responsibility for consulting with the lay therapist on a regular basis and being available for crisis situations.
5. It was essential that the lay therapy coordinator have an understanding of the lay therapists as individuals and

attempt to assign clients that the lay therapist would feel comfortable with as a friend. If there was a strong dislike for certain kinds of behavior or personality types, it was important for the lay therapist to be comfortable in refusing the case.

Supervision and Role of the Coordinator

Lay therapists were provided supervision through three methods. The basic and most essential was a weekly group meeting with the lay therapy coordinator. It was at these meetings that the lay therapists discussed their cases, gave and received mutual support, and expressed their feelings. It was essential during group sessions for a lay therapist to receive support and positive feedback for independent functioning, as well as reinforcement for the knowledge and skill which the lay therapist brought from his or her own life experiences. By hearing the issues and problems that other lay therapists were struggling with, they could more easily put their own struggles into perspective. It was important to create an atmosphere where the lay therapist had permission to make errors in judgement without facing reprimand.

Individual conferences were also necessary at times. These usually occurred regarding a crisis in the family, but they were also utilized when an issue or problem arose which was not appropriate for group supervision. It was important that the lay therapy coordinator be available to the lay therapists on a 24-hour basis, as it was necessary for them to know that they had continued supervisory backup.

The third mode of supervision was that of conferences with the protective service worker. The coordinator encouraged regular communication between the lay therapist and protective service worker in order to help them to get to know each other, feel comfortable with each other, and trust each other's judgment.

It was helpful to include the primary therapist, usually a protective service worker, in meetings with the lay therapists at planned intervals. This served to reinforce the concept of the joint treatment approach. It also allowed for continuing clarification of the differences in the roles of the two therapists with the family. It further allowed for clarification of the function of the coordinator and the primary therapist in their relationship to the lay therapist. The coordinator functioned more as a program planner and group facilitator while the primary therapist acted more as a case consultant.

During group meetings, the lay therapy coordinator identified problems a particular lay therapist was having and related them to other issues discussed in the group. Ideas and suggestions were sought from everyone in the group. The coordinator also identified any gaps in training needs as they existed and planned special sessions in regard to them. It was also helpful to invite lay therapists to attend workshops or agency meetings which were relevant.

In addition, to the responsibilities outlined above, the coordinator served as an advocate for the lay therapists and a buffer between the lay therapist and the system. The coordinator and the protective service supervisor consulted on case management problems. It was the coordinator's responsibility to maintain the role of the lay therapist as a "parent person" rather than a "child person." Other duties of the coordinator included activities to encourage referral, initial screening of cases, and assignment of cases to individual lay therapists.

Group for Parents with Lay Therapists

During the second year of the project, the idea for providing a group experience for the parents who had lay therapists was suggested by the coordinator. The goal of the group was mutual support and an opportunity to share feelings and experiences, since isolation was often a major issue for these parents. It was expected that a group experience would be useful, especially since so many of their problems and concerns were similar. The protective service workers were consulted and they gave their support to the concept which had been expressed by the lay therapists.

The project supervisor and nurse volunteered to act as co-therapists. It was believed that a male and female co-therapist would be an important asset of the group. The nurse was already familiar with many of the families since she had met them during the intake process and it was felt that this might make the group less frightening at first.

Transportation was to be provided by the lay therapists who were also encouraged to attend the group. The time required to drive the parents to the group, attend the meeting, and drive them home became quite demanding for some lay therapists as the group progressed. Orignially, the protective service staff had agreed to offer assistance with transportation if it became a problem. However, the workers were unable to do that on a regular basis and the transportation support staff within Adams County Department of Social Services continually was in short supply.

The group was conducted for approximately six months. It was discontinued primarily because attendance had been reduced to two parents. There were factors in addition to those already mentioned which contributed to the group termination. Choosing a meeting time which was convenient for all became an issue as the parents grew in confidence enough to get involved in other activities, such as jobs or school, and became less available in daytime hours. Meeting in the evening generally conflicted with the lay therapists' schedules.

Additionally, since the project supervisor had a caseload of clients who were at times in crisis, and the nurse was often required to accompany project staff on intakes, both were not consistently present. This was often confusing for the parents and group continuity was difficult to maintain. An additional question which was raised in retrospect was whether involving a parent simultaneously in three treatment modalities (individual, group, and lay therapy), was overwhelming to them. Those parents who did attend on a regular basis, however, did express positive results from the experience and this was confirmed by the lay therapists.

Evaluation

Instruments

Although the adult treatment program of the project was evaluated by Berkley Planning Associates, the lay therapy program was not included as a part of this design. Thus, a design to capture the issues and questions about lay therapy was not a part of the research contract. To the staff's knowledge, no instruments existed at the time the program was initiated to accomplish the evaluation of a lay therapy program.

As a result, the plan for evaluating the lay therapy program, included the following: demographic information on clients served; self-esteem questionnaire to be completed by each parent every six months, with the lay therapist responsible for administration; and a monthly activity report to be completed by each lay therapist for each family. The demographic information was collected at the end of the first ten months of the lay therapy program and the results are included below. A summary of the information collected on the monthly activity reports is also included. However, information regarding the findings from the self-esteem questionnaires is not included as that was not continued on all cases as designed. The lay therapist questioned the usefulness of this tool and as a result it was difficult for them to remember to administer it at the specified intervals.

A questionnaire was devised late in the project to assess how protective service workers felt about the lay therapy program. (Refer to Appendix VII.) This instrument was developed and administered in March and April of 1977. Consequently only eleven families were assessed. It is recommended that this instrument be used on an ongoing basis over an extended period of time before significant conclusions are drawn.

Another instrument was developed by Family Center staff to evaluate treatment results. (Refer to Appendix XII.) This instrument could be adapted for use at various times with families assigned a lay therapist. Using both of the questionnaires described in this section would result in an effective assessment of lay therapy programs and offer a method for measuring progress of individual cases.

Summary of Findings

During the project's duration, 32 families received lay therapy services As the project ended, 13 of those families were still active cases. The reasons for closing lay therapy cases were, in order of frequency: 1) family moved; 2) lay therapist left the program; 3) family referred for treatment elsewhere; and 4) family refused involvement of a lay therapist.

The profile of the families referred for services in the first ten months of the program was as follows: Average age of parent, 26½ years; average number of children in the family, 2.7; severity of abuse, 29% severe abuse, 29% moderate abuse, 12% mild abuse, and 30% potential abuse; and income level, all families had incomes less than $10,000 and 21 percent were receiving public assistance.

Each lay therapist completed a monthly contact report for each family. From these reports, the following data was collected:

Primary Reason for Contacts with Parent

- Visiting and Companionship	68%
- Food Shopping	2%
- Babysitting	2%
- Recreation with Parent	5%
- Recreation with Parent and Child	2%
- Assistance with Employment	1%
- Assistance with Family Finance	1%
- Assistance with Medical Needs	1%
- Assistance with Housework	4%
- Nutrition and Meals	1%
- Transportation	9%
- Other	4%

Type of Contact

Home Visit	55%
Telephone	45%

Person Initiating Contact

Lay Therapist	72%
Client	28%

Average Number of Contacts Per Month = 76

Average Length of Contact = 1 hour, 30 minutes

Major Changes Occurring in Family During Lay Therapist Involvement

	Total Change	Percentage of Total Change
Change in Marital Status	5	8%
Change in Employment	16	26%
Change in Address	9	14%
Serious Illness	23	37%
Placement of Children	2	3%
Other	7	11%
	62	

Lay Therapist Contact with Protective Service Worker

Type of Contact	
Office	34%
Telephone	66%

Person Initiating Contact	
Lay Therapist	70%
Worker	30%

Average Length of Contact = 20 minutes

Average Number of Contacts Per Case Per Month = 1.05

An additional question asked each month was "Did abuse recur during the month?" A reoccurrence of abuse was defined as meaning that abuse was reported to the protective service worker and documented. Abuse recurred in only one family, and this occurred in a family where the original abusive incident had involved the death of another child within the family. The severity of the recurred was documented as mild.

Techniques of parenting described by the lay therapist fell into two basic categories: 1) parenting techniques related to the client's children; and 2) techniques related to reparenting for the client by the lay therapist. The techinques used which involved the client's parenting of the child were: (a) discussions of parent-child communication; (b) discussions and actions regarding the needs of the child for additional services such as speech therapy, tutoring, evaluation, etc; (c) modeling "how to play" with children; (d) modeling behavior modification techniques; (e) discussions regarding appropriateness of parental expectations of the child; (f) information of child's developmental stages; (g) counseling regarding consistency of discipline; and, (h) counseling regarding helping the child to express his real feelings.

Activities involving reparenting the parent included: (a) encouraging the client to take care of himself or herself; (b) encouraging the parent to follow through on individual goals; (c) encouraging the parent to be more assertive; (d) giving advice on how to improve housekeeping; (e) providing praise for doing a good job with the child; (f) encouraging the parent to plan leisure activities for self; and (g) allowing for expression of negative feelings toward the lay therapist.

The results of the protective service worker's evaluation questionnaire indicated that the primary reasons for referring a case for a lay therapist, in order to priority, were: 1) to reduce the parent's isolation (73 percent); 2) to increase the parent's self-esteem (54 percent); 3) to increase the parent's self-reliance (27 percent); and 4) to provide the parent a model for good parenting behavior (27 percent). Other reasons for referring a family for a lay therapist were as follows: to provide the parent assistance in following through on individual goals; to provide the parent with education on child-rearing practices; to provide the parent assistance in changing patterns of parent-child interaction; to provide transportation; to monitor for abuse; and to assist mother in her separation from her husband.

In 55 percent of the families the priorities for maintaining a lay therapist with a family were the same at the time of the evaluation as they had been at the time of the referral. If the goals had changed, the reasons were as follows: In one family the initial goals were reached (9 percent); in two families the family situation had changed (18 percent); in two families some of the goals had been accomplished,and this shifted the priorities to other goals (18 percent). In no case did the worker feel the goals were unrealistic.

In the 45 percent of the cases in which there was a change in the priorities, the reasons for maintaining a lay therapist were, in order of priority: to increase the parent's self-esteem; to provide the parent assistance with following through on individual goals; and to reduce the parent's isolation.

Workers were asked to assess client goal attainment on a scale ranging from minus ten to plus ten, where 0 indicated the functioning. The average score given was a positive score of 4.82. Almost half or 46 percent received a positive score of six or above. The workers were asked to assess how responsible they felt the lay therapist was for the client's progression or regression. On this scale the 0 point indicated that the lay therapist was not responsible for the client's movement and the 10 point positive mark indicated that the lay therapist was totally responsible for the client's positive movement. The results from this question indicated a mean score of 5.36. In this question 36% received a score of seven or above.

When asked if the protective service workers felt that the lay therapist contacted them at appropriate times and used the contacts appropriately, in all but one case the workers answered affirmatively. In the one case the worker felt the lay therapist should have initiated more frequent contacts. The final sections asked for the general comments made by the client as well as general comments by worker. In general the comments from both were positive. In two cases, the client had expressed the feeling that the lay therapist did not have enough time for them. This was echoed by the worker in those cases also. Additionally, in two cases where the lay therapist terminated because of leaving the program, the worker felt this was not handled well.

Issues

One major difference between the Family Center lay therapy program and that of the National Center for the Prevention and Treatment of Child Abuse and Neglect was in the length of time which was planned for training. As stated earlier, the Family Center training covered a 2-3 week period, while training at the National Center was planned for three months. The advantages of a shortened training period was that it allowed the lay therapist to get involved with families at a time when their enthusiasm was highest and their training experiences were fresh, as well as maximizing the time of their direct involvement with parents. There was also a value to problem solving with actual situations. The risk of the shortened training period was that the lay therapist might be less comfortable and less knowledgeable, as well as there not being sufficient time for the lay therapy coordinator to evaluate the lay therapist's skills and commitment prior to case assignment. Decisions on this issue will probably vary with the time limitations of the agency, prior experience and training of the lay therapists, and the philosophical orientation of the program coordinator.

One of the initial program considerations was whether lay therapists were to be paid or to be volunteers. The decision was made to pay lay therapists although some volunteers were used through the project. One of the reasons for this decision was this would facilitate recruitment of lay therapists from all socioeconomic levels. Without some compensation for personal expenses, low income persons would be unable to accept positions as lay therapists. Money does have value as a motivator and is not in conflict with a motivation of wanting to help people. Wages can also be an indication of the value of a service performed to the agency requesting the service. The experience of using some volunteers created another reason for paid lay therapists, which was that the volunteers each worked only a few months while the average tenure of paid lay therapists was over 18 months. Having paid lay therapists was an indication of their value as salaried employees in the protective service system.

Throughout the project, attempts were made to recruit men for the position of lay therapist. Despite these attempts, only a small percentage of applicants were men. Of these applicants two men were hired. Unfortunately, one man left the program for personal reasons following the training period and the other man worked with a family for six months before returning to school. One difficulty in recruiting men was the requirement that lay therapists commit 15 hours weekly. Since most men would be fully employed, as well as having family commitments, this time involvement may be excessive. Another difficulty in recruiting men was the pay scale, which was below minimum wage. Additionally, recruitment of men was made more difficult by the fact that the lay therapist has traditionally been a woman.

A continuing issue involved in the lay therapy program was the relationship between the lay therapist and the protective service worker. As has been discussed in previous sections this relationship contained some inherent problems. It was critical for the protective service worker and the lay therapist to respect one another's skills so that they did not find themselves suspicious and competitive. It was also important that they each have a clear understanding of the other's role. A tendency of protective service workers that was experienced by the Family Center project, was to withdraw their involvement with the family after a lay therapist was involved. This appeared to be precipitated by the time pressures of their caseloads and their belief that a lay therapist could monitor the case and "keep things calm." This was an ongoing problem of interpretation and coordination which became one of the functions of the lay therapist coordinator. It would be critical for any lay therapy program to encourage regular contact between the protective service worker and the lay therapist.

The lay therapy concept can be utilized in other settings and with families with problems other than child abuse and neglect. Since lay therapy is basically a reparenting process, it would be appropriate to utilize this modality with a wide range of clientele. The Family Center program limited its referrals to abusive or potentially abusive families because of the program goals as well as a conviction that, since the programs was of limited size, it should focus on serving the high-risk group.

Adaptability

The Family Center lay therapy program achieved the goal of demonstrating the applicability of the lay therapy concept within a protective service setting. The program has been accepted into the Adams County Department of Social Services at its present level. Each lay therapist will be under contract and the monies will be part of the agency's contractual funds rather than personnel funds. Lay therapists will not be considered regular employees and therefore do not need to use any of the personnel slots allocated for the department. One change made at the time of the transition was the decision to permit lay therapists to contract for less than a full fifteen hours. They are to contract for 5, 10, or 15 hours weekly, which would result in their assignment to one, two, or three families. This will allow those lay therapists who have been with the program for some time, but who have developed other interests or commitments, to remain within the program. This is critical not only to the families with whom they are working, but these experienced lay therapists have much to offer new or less experienced lay therapists. Additionally, this new flexibility should permit recruitment of applicants who would be good candidates but would not be able to commit a full fifteen hours a week.

Adams County Department of Social Services has allocated one staff position for a Resource Coordinator. Part of the duties of that position will be to coordinate the lay therapy program.

TREATMENT OF CHILDREN

Ann Brown, Mark Grassman
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Introduction

The goals of the treatment of children program component were: (1) to provide individual and/or group therapy to abused children (2) to experiment in the implementation and coordination of these treatment modalities, and (3) to measure the relative effectiveness of these various treatment plans.

The stated objectives of this component were: (1) strengthening the child's ability to form positive attachments, (2) resolving the separation anxiety precipitated by a loss, (3) minimizing the predominance of withdrawn or acting out behavior, and (4) improving the child's self esteem.

Case Selection

Cases were selected by the social workers on the basis of personal interest in working with a given child. Many individual child treatment cases were selected after a Family Center social worker completed an abuse intake. In devising a case plan prior to referring the family to the department of social services, it was arranged that a Family Center social worker would assume the child's treatment responsibility. Children's groups such as the latency age group and the affective speech therapy group, were filled on the basis of referrals from the project and the department of social services. Notices were distributed describing the goals and objectives of the groups and the necessary criteria for making an appropriate child referral. Table 1 presents the demographic data on children referred for treatment.

Initial Diagnosis

A preliminary diagnostic evaluation of the abused child required knowledge of the child's family and medical history, in addition to an awareness of the child's social functioning and personal self concept. Without a basic understanding of these four areas the initial evaluation would lack the comprehensiveness needed to develop a sucessfully coordinated treatment plan.

Family History

The first major area of evaluation involved obtaining a clear picture of the history of the child's role within the family. It was often the case that the child who had been abused within a family had historically been scapegoated by the other members. It was important to understand the dynamics of the situation; how it developed, and how the other family members along with the child in question were contributing to maintaining the stressful situation.

In regard to the particular abuse incident, it was noted whether or not the child was abused by a family member currently living in the home and his relationship to the child. Any additional information concerning the precipitants of the abusive incident with regards to the child's provocative behavior patterns and the parent's impulsive reaction to stress was important in formulating an initial diagnosis. Aside from identifying the abusive pattern and the negative parent

TABLE 1

DEMOGRAPHIC DATA ON CHILDREN REFERRED FOR TREATMENT

	Number	Percent
Total Children	29	(100)
Sex		
Male	20	(69)
Female	9	(31)
Ethnicity		
Anglo	22	(76)
Chicano	1	(3)
Other	2	(7)
Missing	4	(14)
Age		
Upper limit - 15 years	Mean age - 7.5 years	
Lower limit - 2 years	Median age - 6.7 years	
	Mode - 6.4 years	
Severity of abuse		
Severe	1	(3)
Moderate	9	(31)
Mild	3	(10)
Emotional	1	(3)
Potential	15	(52)

involvement, it was also advisable to identify those family members who were particularly significant to the child's positive growth potential. Knowledge of these persons was helpful in developing a comprehensive, coordinated treatment plan for the child.

Medical History

Particular attention was given to the child's medical history in determining an initial diagnosis. Questions of interest were (1) were there any significant problem areas associated with the child's prenatal development? (2) were there any labor or delivery complications? (3) were there any congential birth defects? and (4) were there any medical concerns necessitating an extended hospitalization period of either the mother and/or the child? The answers to these questions were as important source of information in regard to assessing the initial parent-child bonding process.

The therapist should also assess any medical problems that the child might have developed later on such as asthma, allergies, seizures, etc. A child who had been inflicted with serious medical ailments made additional demands on a parent in terms of emotional, physical, and financial resources. These unavoidable consequences of extensive medical care can be a stressful situation for the parents. Their frustration was often directed at the child and severly interfered with the development of a positive parent-child attachment.

Social Functioning

Another major area of interest during this diagnostic process concerned the child's ability to relate to adult and age mates in both individual and group situations. The abused child typically demonstrated either severely withdrawn or overly aggressive behavior at home, at school or in the community. It was important to assess the age appropriateness of the child's behavior in these different settings. This entailed an evaluation of the child's interaction at home with his parents, at school with his teachers, after school with the babysitter, and any other system making a significant impact, positive or negative, on the child's life experience.

In some situations cultural factors may have had a very significant influence on the child's demonstrated behavior pattern. This factor was particularly relevant if the child was from an ethnic minority group. An abused child, who is already trying to cope with a poor home environment, had an added burden of trying to adapt to a racially prejudiced setting away from the home. If this situation did exist, it was important information to note in the diagnostic write-up.

Personal Self-Concept

A final factor considered was the child's perception of himself and his role within the family. Many times an abused child had internalized the family member's message that he was a "problem." If this was the case, it was important to explore the child's feelings involved in the integration of such a poor self concept. Did he view himself as being a bad person, deserving of his parent's abuse, or did he see himself as being rejected and unwanted by others, especially his parents? Knowledge of the child's personal perception is essential to understanding the gestalt of the child in his environment.

Development of the Treatment Plan

Generic Assessment of the Child

In describing a treatment plan for a given child, it was necessary to review the total picture of the child as presented in the diagnostic work-up. Those systems having a healthy influence on the child need to be contacted in order to engage them in actively participating in supporting a coordinated plan for the child.

Those systems currently having a negative influence also needed to be contacted in the process of implementing a treatment plan. They were particularly significant in lieu of the possibility that they might sabotage the child's therapy. It was extremely important to work with these systems in much the same manner as a therapist would another client. This approach was necessary in order to attempt to understand the system's need to inhibit the child's growth, and uncover the causal nature of its unhealthy interaction with the child. Once this issue was dealt with more directly, both the child and system could move towards positive growth.

Child Treatment

The concept of approaching the totality of the child's functioning is not new to the field of child treatment. It does, however, meet occasional resistance from therapists who traditionally structure the entire treatment plan into weekly individual sessions with the child. Treatment with abused children in particular demands a more open approach. Coping with the trauma of the abuse experience requires considerable psychic energy which interferes with the children's mastery of age appropriate developmental tasks. As a result, the child falls behind in his language, motor and/or cognitive skills. The child's potential for growth remained limited if all these domains of functioning were not pursued in the development and implementation of a coordinated treatment plan. However, it was not possible to provide such a comprehensive focus due to the resistance of some systems to cooperate. In these cases, it was necessary to accept the reality of the deficit and look for alternative methods of intervention.

Modalities of Treatment

In addition to coordinating the child's support systems, a major responsibility of the therapist was to provide direct services to the child. This part of the treatment plan either took the form of individual or group therapy. Variations and modifications upon the traditional techniques of intervention were frequently made in order to address more directly the issue of abuse. (Refer to Table 2.)

Individual Therapy

The decision was made to treat a child on an individual basis if the presenting problems appeared to be severe enough in nature to merit direct one-to-one attention. Typically, individual therapy was effective in helping the child establish a positive relationship with an adult. Although this process was inherent in group therapy, it could not be given the direct guidance and facilitation that was possible within the structure of an individual session. Therefore, a major factor in assessing whether a child was to be treated individually centered around the child's ability to form attachments. This developmental task must have been on its way to mastery prior to introducing the child to an even higher developmental task involving peer socialization capabilities inherent in a group process structure.

TABLE 2

MODALITY OF AND LENGTH OF TIME IN TREATMENT - CHILDREN

Type of Treatment Received*	Number	Percent	Average Month in Treatment
Play Therapy	11	(40)	8.1
Therapeutic Day Care	6	(21)	6.1
Therapeutic Foster Care	1	(4)	9.7
Individual Psycho Therapy	5	(18)	10.5
Family Therapy	3	(11)	7.5
Crisis Nursery	2	(7)	1.3
Other (treatment provided outside project)	3	(11)	7.5

Average length of time in treatment for all children in all treatment modalities 7.6 months

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* Since some children received more than one form of treatment, the total number of children recorded here is greater than 29.

In many cases, however, the child had reached some level of mastery in forming a positive relationship with an adult, but demonstrated behavior problems which could not be handled in a group situation and did merit more individual attention. Group process could not accomodate children who displayed severe impulsive or withdrawn behavior. A child who was overly aggressive did not allow the group sufficient time to develop the strength to withstand his/her provocation. A child who was overly shy and refusing to communicate, gave the impression of hostility and was not involved in the group.

Group Therapy

As stated above, if the child had sufficiently mastered the task of relating positively to an adult, he/she was prime for a group experience to develop positive ways of interacting with his age mates.

Often the focus of individual treatment was to work through the issue of attachment and to prepare the child for an eventual group setting. This approach provided for a smooth transition in the treatment plan.

Screening was a key issue in the forming of children's groups and was particularly critical to working with abused children. The potential members were carefully screened so as not to cover too large a developmental age range (2 - 3 years maximum) nor too large a personality profile. In establishing a group, it was important that personalities and problem behaviors be mixed in such a manner that they complimented each other and did not cause the inappropriate behaviors to escalate .

Acting out, aggressive behavior was a common characteristic of abused children who, unless the problem were severe, could still be appropriate for a group experience. The problem lies in the screening process which necessitates that this acting out behavior be neutralized by more children who had withdrawn problems. This was necessary in order to avert the escalation of the group's collective aggressive drive, which will become unmanageable for the therapist to control. Consequently, in forming a group, it was necessary to combine non-abused children demonstrating withdrawn symptoms with acting out abused children, if the selection abuse sample did not provide this natural variation.

There were several contingency factors which were considered in determining whether or not the direct service provided to the child was a group or individual therapy. These contingencies involved situational realities such as the child's place of residence which may have been in an outlying area and isolated from the cluster of the other group members; inavailability of regular transportation to and from the group meeting place; and/or parents objections to their child's participation in a weekly group session. These factors very often provided stumbling blocks which could not be sufficiently overcome, and which necessitated the modification of the initially formulated treatment plan.

Affective Language Group

Midway in the project's operation, the research data pointed to significant discrepancies in the children's skill building deficits and the corresponding progress in their therapy. This opened up discussion concerning the need to expand the traditional definition of child therapy to include not only intrapsychic focus but skill remediation in the areas of language and cognition. Two such experimental approaches were attempted by a project social worker who also had a background in early childhood education.

This group was comprised of eight children whose ages ranged from two and one half to three and one half years old. All the children demonstrated language deficits including a congential cleft palate, difficulty in articulation and syntax, and/or inaudible speech. Three of the children were referred from the department of social services, protective service units. The other five children were referred by either public agencies or the child's own parents. They had either a history of severe abuse which necessitated foster placement and/or termination of parental rights, or mild/moderate abuse or neglect which did not require that the child be separated from his parents. The group was lead by a project social worker, a speech pathologist, and two speech pathology trainees.

The group ran for a total of five months and met twice a week for one hour sessions. The session was divided into three time periods in which activities were specifically defined. The initial half hour was devoted to language skill building exercises and was led by the speech pathologists. Following this was a break during which the children had a snack and engaged in free language socialization. The remaining twenty minutes was used for the affective, free association component of expressive language skill development. This period was used by the project social worker with assistance from the speech pathologists.

Considerable energy was expended to coordinate the language and affective components of the group. This became an increasingly difficult task as the speech pathologists and project social worker ran into idealogical conflicts involving the use of structure. The process of speech therapy demands considerable structure in modeling correct articulation and snytax until the child has integrated the concept and can repeat the sentence structure correctly. In contrast, the process of affective speech therapy or emotive therapy, demands that there be enough freedom to facilitate free association of feelings. The essential difference between these two processes was the verbalization of feelings necessitating a strict grammatical structure, while the experience of feelings necessitated an open, nondirective setting.

The resolution of these idealogical differences provided a complementary coordination of grammatical and expressive speech skills. The group leaders decided that the first period of the group would remain very structured with the purpose of introducing the children to language labels and patterns. For example, several sessions were spent teaching the children the words "mad," "sad", "I am happy." The emotive sequel to this lesson was then presented in the second half of the group session. The purpose of this affective period was to provide opportunities for the children to experience these various emotions and to be able then to match the feelings with the appropriate grammatical label. This process of "putting feelings into words" was initiated by the use of group puppet play, dramatic play and story book readings.

A particularly successful implementation of this process was the use of animal stories, in particular *The Three Bears*. The children were familiar with the storyline and therefore were able to describe what was happening in each of the illustrated events. They were able to appropriately label the feelings of joy, anger, and sadness portrayed by the bears' facial expressions. Initially, it was less threatening for a young child to identify feelings in relationship to animals instead of humans.

As the group cohesiveness strengthened, the children assumed the roles of Mama Bear, Papa Bear and Baby Bear themselves with the aid of minimal costuming and props. Finally, as the children felt secure in the expression of the bears' feelings, they were able to move on into the realm of expressing their own feelings. This was facilitated by the therapist who would make transitional statements such as "Baby Bear is angry because his chair is broken. What things make you angry?"

In assessing the outcome of the group, the staff observed significant progress in terms of the children's language articulation and syntax. The ability to label feelings varied from child to child, but in general, there was a definite increase in the frequency in which they spontaneously engaged in this behavior. Group support developed around the expression of feelings and staff reinforced this process considerably.

Cognitive Therapy

The concept of cognitive therapy or therapy in the classroom is relatively new to the field of child treatment, and the project did not locate any research identifying this approach in working specifically with abused children.

One project social worker attempted to integrate a cognitive therapy approach into the treatment planning for an eight year old boy who had been moderately abused. Several contacts were made with his two teachers in his learning disabilities class prior to the start of the treatment sessions. The teachers had initially requested individual treatment for the child because they recognized a need for him to receive nurturance or "tender loving care," as they described it. For reasons which were unknown to the social worker at the time, they stated that they could not provide him with this because it conflicted with their authority role as teachers. Without confronting this statement, the social worker asked for their help in defining goals and objectives for the child's treatment plan.

For the first two months of treatment, the child was seen weekly in individual therapy sessions outside the classroom. This was necessary in order to build a trusting relationship between the therapist and the child. Then the therapist began to spend the first fifteen minutes of each hour in the classroom sitting next to the child while he was working at his desk. Gradually this time increased to include the full hour. The focus of this therapy in the classroom was a problem solving approach, dealing with the skill areas of cognition and social interaction. For example, when the child was frustrated by a difficult math problem and turned around to look at his neighbor's answer, the therapist would help the child consider the consequences of such an action and explore whether there were other alternatives to seeking the arithmetic answer.

Considerable time was spent with the teachers after each session to relay feedback and to exchange ideas in terms of what new problem areas needed attention. The teachers gradually became more actively involved in this process and on their own initiative planned special group activities to elicit emotive responses from the children. These activities, although initially designed for the specific child, had considerable benefits for all the classroom children.

In assessing the outcome of this treatment approach, one cannot overstate its impact. The two teachers, who initially saw themselves solely as teachers and not as child advocates, took on the new responsibility of integrating affectual components into the academic curriculum. Such an approach has tremendous multiplier effects and is consistent with the concept of a coordinated multidisciplinary treatment plan. The classroom treatment provided a positive environment which strengthened the child's self concept and enhanced emotional maturity. The child was able to adapt successfully to his classroom environment.

Children's Group

Two project social workers initiated a play therapy group for abused and potentially abused children. The purpose of the group was to provide a therapeutic play setting for children who had difficulty relating to their peers and adults and verbalizing their feelings. The objectives of the group were to increase the social interaction skills of the children, and to assist the children in appropriately expressing their feelings. The criteria for participation in the group included: abused or potentially abused children; boys or girls, ages six to eight; children who could benefit from a group setting; children who may have been withdrawn; acting out, or insecure; children who had difficulty in relating to peers and adults; and children who had difficulty in appropriately expressing their feelings. The group lasted for one year. Four of the children participated for the entire year, and three children participated for less than two months.

In order for the group to begin, the two project staff members were involved in implementing a referral system, securing a meeting place, purchasing toys, and obtaining transportation. They agreed to accept referrals from protective service units and the schools. They sent a memorandum to all of the supervisors in the social service department and contacted social workers in each of the counties' school districts. The criteria for accepting children into the group was listed as well as a written referral was requested. In addition, the group leaders planned to screen prospective group members by interviewing them and their parents.

The project staff obtained a place to meet by contacting several schools, churches, and mental health offices to assess the availability of space. One school social worker was instrumental in helping the group obtain the use of a recreation center in School District 50. The center had indoor and outdoor space as well as some recreation equipment which the group used at no expense to the project.

The project purchased play equipment which would facilitate group interaction, the practice of motor skills, and feelings of mastery and confidence. Some of the toys included paints, puppets, puzzles, clay, a doll house, a punching bag, and sports equipment.

One of the most important implementation tasks was obtaining transportation for the children. Initially two parents brought their children, while the group leaders brought the other children. Later, a case aide from the Department of Social Services arranged to transport the children.

In assessing the children's group the leaders/therapists became aware of its strengths and limitations. The major limitation seemed to be that the goal or purpose of the group was vague and unclear to the children. The idea of helping children relate appropriately to their peers and other adults, and to express their feelings was more of a hidden agenda for the therapists than a stated goal which the children understood and were committed to. As a result the children saw the weekly group session as a free play time with no connection to some of their problems at home or at school. A second limitation was the lack of support from the parents of the children. Most of the parents passively stated that the group sessions would benefit their children, but they expected the therapists to do all the work. The screening process should have included a diagnostic and contract session with the parents where their committment to their child's individual goals could have been discussed and agreed upon.

The major strength for the group was the fact that four boys remained in the program for the entire year, and it developed into a cohesive group. They started to share toys, and they showed some ability in expressing their feelings appropriately instead of impulsively acting out their emotions.

In considering the possibilty of repeating this group experience in a department of social services or any other setting the group leaders identified several issues that need to be settled before the group begins. In addition to the transportation and screening problems which have already been mentioned, the group leaders must expect to spend a lot of time conducting a group. They should also anticipate receiving a lot of angry acting out behavior from the children. Therapists expended an hour and a half each week in the actual group meeting and another three hours each week in preparing for the group, discussing what happened the previous week, dealing with co-therapy issues, and talking with the parents.

The children's group differed from a "normal group" of children that same age in the frequency and intensity of acting out angry feelings. It was not uncommon for all of the children to spend the entire session attempting to physically punch and kick each other. The group leaders found this very frustrating in terms of maintaining a safe atmosphere for group members as well as encouraging the appropriate expression of feelings. Some of this behavior could be attributed to bound up energy after being in school all day; however, the children also had a difficult time maintianing any impulse control and attending to any task for more than five minutes. Their angry behavior also manifested similar dynamics in their relationships with their families.

In summary the project staff involved with the children's group felt that it was primarily a learning experience. They encountered usual issues such as changing staff, defining goals, and finding enough time to conduct a group with co-therapists. They also discovered unique issues such as the uncertainity of transportation, the lack of parental support, children's angry behavior, and the intensity of abused children's aggressive behavior. As a result of this experience abuse programs should try to develop other methods than free play for enhancing children's interpersonal skills and as a means of teaching them appropriate expressions of anger.

Major Themes

The major themes found in treating abused children involved the following problem areas: inability to form positive attachments; separation anxiety precipitated by an experience of a loss; depression manifested by acting out or withdrawn behaviors; and low self esteem. These issues all need to be dealt with in the treatment process regardless of the type of therapeutic setting.

Inability to Form Positive Attachments

The abuse dynamic is cyclical, and for the same reason that abusive parents did not experience sufficient nurturance and/or consistent limit setting from their parents, they, in turn, are not equipped to provide these necessary parenting functions to their children. The result is that these children never successfully master the primary developmental task described by Erik Erikson as Autonomy vs. Shame and Doubt, and similarly portrayed by Margaret Mahler as the Separation and Individuation process. Without an early experience of being reassured that mother is available and in support of their exploration of the unknown, children are unable to form a genuine relationship with another individual.

Separation Anxiety Precipitated by a Loss

The anxiety that develops when an abused child experiences a loss is markedly intense. As with children who are victims of early parent loss through death, the abused child experiences mother's emotional unavailability as a loss and interprets this message as a rejection. Any separation from a meaningful adult carries the potential of being a permanent termination for which the dependent child is unable to tolerate and becomes extremely anxious. This anxiety is replayed throughout the therapeutic contact with the child. Any temporary separation, no matter how minor in nature, precipitates anxiety for the child. This occurs at the end of the hourly session, at the time the therapist goes on vacation, and the most severe situation is the actual termination of the treatment process and relationship. The developmental deficit becomes manifested in two general affective types: (1) either the child demonstrates a strong dependency upon others, or the reverse, (2) an aloof, almost autistic response to people. The majority of the abused children who were treated in this project fell within the dependency category. This dependency category can be sub-divided into (1) clinging behvavior; needing to be with mother all the time; clutching to mother's skirt; (2) the role reversal patterns in which the child takes care of mother's needs. Both patterns demonstrates a deep dependency and fear that mother will abandon them. By always being in her presence or taking care of her the child tries to establish a secure base from which he can experiment, practice, and return knowing that mother will be there.

Depression Manifested by Withdrawn or Acting Out Behavior

The frustration that the abused child experiences in receiving inadequate parental nurturance coincides with the frustration of his own parents because their similar history of unmet needs. Abusive parents fall into two categories, passive abusers and active abusers. If the child's role model for dealing with frustration was passive, then the child will learn to handle his frustration in a withdrawn manner. If the child's role model was physically abusive when feeling frustrated, the child continued this pattern. For his/her protection, though, he will not act out at home, and more frequently the classroom becomes the arena for such behavioral expression.

Both these withdrawn or aggressive behaviors are indicators of a depression caused by the loss of mother's availability and nurturance. The young child attempts to defend against experiencing this depression by becoming either ragefully explosive or passively withdrawn.

Low Self Esteem

Abused children commonly portray a poor self-image due to their abusive history and their developmental lags, as demonstrated in the project's research data. The repeated experience of being hit, tends to reinforce that they are indeed bad and deserving of such punishment. If they are experiencing failure at school because of a developmental deficiency, the perception of a negative view of themselves becomes internalized and perhaps intensified by the phenomenon of the self fulfilling prophecy.

Establishing a Therapeutic Alliance

Initiating a therapeutic relationship with an abused child was particularly difficult because of their difficulty in forming positive attachments to adults. The child was extremely defensive and would not engage in significant communication with the therapist. This stems from ambivalence caused by a fear of being close and a wish to be near. This struggle was acted out through such symptomatic behaviors as severe withdrawal and minimal eye contact with the therapist. Conversely, the children became extremely agitated, ran out of the room, and/or played wildly with all the toys without engaging with an particular one for any length of time.

The process of breaking through this defensive stance was demanding and required a lot of time and patience. It was important that the therapist set limits and insure consistency for the therapeutic hour. This was necessary in order to provide the child with a secure environment in which he/she was comfortable in attempting to break through the social isolation and take steps to relate to an adult.

Group therapy provided an additional component to this initial phase of developing an attachment. A child has to learn to relate to the adult therapist, but also relate to his age mates. Children suitable for group process had greater capacity for attempting such relationships than those selected for individual treatment. Yet, the initial phase of treatment often precipitated a temporary regression. The therapist set firm limits and remained consistent in enforcing them in order to provide an environment conducive to the development of group cohesiveness.

During the preliminary stage of treatment, it was equally crucial to establish a working alliance with the child's significant other systems. Alliances were most easily made in situations where the therapist explained his/her involvement with the child as an adjunct to other existing relationships with the child. This approach served to minimize the possibility of a competitive situation developing between the therapist and the other significant people in the child's life. It was advantageous for the therapist to express his/her need to utilize their help and experiential knowledge in working with the child to devise a coordinated treatment plan.

Middle Phase of Treatment

Treatment proceeded to the middle phase when the child felt comfortable enough to relinquish a defensive stance and to explore the experience of having a positive relationship with the therapist. Abused children tend to relate to adults in an inconsistent, insincere, manipulative, non-spontaneous, and non-age appropriate fashion. The therapeutic relationship provided the abused child with an opportunity to relate to an adult who did not expect the child to take care of him. The therapist encouraged the child to respond in an age appropriate and independent manner.

In the new experience the child frequently regressed and tried to produce an abusive relationship with the therapist. The child reverted to his old ways of being provocative and/or needing to please adults.

It was important that the therapist remain consistent in his/her way of relating to the child, despite the child's attempts to reverse its positive qualities. Clinical supervision of the nature which explores the positive and negative counter transference issues stirred up by this regression, was important during this phase. The therapist needed to be aware of the angry feelings which the child was trying to evoke. The therapist's awareness allowed him to tell the child about his attempts to make the therapist angry. When this was interpreted in a non-defensive manner, the child experienced a new way of relating and was not rejected for negative feelings. Similarily, the therapist needed to be aware of the positive feelings that were aroused when the child needed to please the therapist. Frequently the child wanted to defer to the therapist in an attempt to placate him/her as a means of securing the relationship. This need was acted out in several ways, including the child's asking the therapist what he wanted to do during the therapeutic hour, the child's needing to give presents to the therapist, and the child's offer to have the therapist start first in a game. The therapist needed to reverse this pattern over time. This was done planfully in order to avoid having the child experience a sense of personal rejection when the therapist did not accept the child's need to see him as someone whom he must please. This message was interpreted to the child experientially by reinforcing age appropriate child-like behaviors and discouraging inappropriate, adult-like role reversal.

In a group setting, children had the additional experience of relating to their age mates in a positive, genuine, and open manner. Peer interaction within an abused children's group tended to re-enact and work through the abusive family roles. One child would assume the abusive parent role and act out his aggression, arbitrarily with another group member. These role playing patterns informally shift throughout the group session and became standard group behavior if the therapist did not take a direct role in minimizing the frequency and interpreting the significance very early in the group. The therapist needed to be active in modeling positive interactions with the group members in order to present alternative ways of interaction. In this setting, the child was introduced to positive ways of relating to both adults and peers, and this was a novel experience for many of the children.

Closely related to the issue of attachmemt, the concept of self esteem was also an important theme during the middle phase of treatment. Whether in a group or individual setting, the child received validation for being himself. This was in contrast to his past abusive experiences which reinforced that he was innately bad. Therapists and group members were supportive in accepting the child's personality and acknowledging his strengths without rejecting him for his negative behaviors. It was important for the therapist to consistently give the message that the child was a good person in spite of his occasional and sometimes frequent disruptive actions.

In addition to validating the child's feelings of self worth it was also important to assess areas of functioning that needed remediation in order to build his self esteem. Often abused chidlren are developmentally deficient in either language, cognitive and/or motor skills and this deficiency can serve to perpetuate a poor self concept. It was at this time that coordination of community resources played an important role in the therapeutic process. It was necessary that the child be given additional speech therapy, academic remediation and/or physical therapy to augment the work being done in his therapy. Such a systems approach to the treatment process helped strengthen the child's positive self-image in all his areas of functioning.

As the middle phase of treatment proceeded, the issue of separation anxiety precipitated by loss became a major theme. Separations were a particularly painful experience for the abused child whose parent had been physically and/or emotionally unavailable to him. The pain associated with this earlier loss was evoked in therapy when the child sensed a loss of the therapist's availability. These feelings surfaced at the end of the hourly sessions, when the therapist would go on vacation, or when an appointment time needed to be cancelled. The first task in the process of working through the perceived loss was to help the child label whatever feeling he was consequently experiencing. It was a comfort to the child to know that the numbing feelings inside his tummy has a name such as anger or sadness. More importantly, it was reassuring to the child to know that another adult understood what was going on inside him and was willing to listen to him. The second task was to encourage the child to express these feelings himself and to help him learn new ways of effectively coping with the issue of loss. At the end of the hour, the therapist discussed with the child what both would be doing during the week. This helped the child who was struggling with the issue of object constancy to internalize a mental picture of the therapist's activities. This technique allowed the child to experience the temporary loss of the therapist with a lowered level of anxiety, knowing that he/she would return in a week.

Throughout the entire treatment process, the issue of anger was of prime importance. The middle phase of therapy allowed an opportunity for the child to express his feelings of anger towards his parents by transferring them on the therapist. The therapeutic alliance needed to be strong enough to support the child's anger without harboring indirect messages of rejection. Typically, the abused child had been negatively reinforced for displaying angry feelings in his/her home. His/her display of anger stirred up his parents' similar feelings of unresolved rage and the situation became intolerable, and treatment helped the child learn appropriate methods of expressing anger.

The group setting accelerated the process of dealing with unresolved anger. The children found support in knowing that other group members experienced the same reactions and feelings. Appropriate expression of constructive anger was modeled within the group by therapists and children. It was important that the group be carefully balanced in order to avoid a contagious release of diffuse, uncontrollable, acted-out anger.

Termination

The issues of loss and anger was a primary focus during the termination phase of treatment. If the decision to terminate was indicated, and not a reaction to external circumstances, then this final stage of treatment provided an opportunity for the child to master the developmental task of separation and individuation. The child initially regressed to demonstrating symptoms of severe separation anxiety and diffuse anger during the treatment hour. The ending of a session would become extremely significant to the child in that it did stir up feelings of the impending, more lasting separation from the therapist. However, if the treatment process had sufficiently worked through this issue of loss and the resulting anger, depression and rejection, then the termination phase allowed the child to experience a separation in a healthy, positive fashion without injuring his concept of self adequacy.

Planned terminations, unfortunately, were not the norm when working with abused children. Families moved, children were placed in foster care, children were adopted out of state, and sometimes parents aborted the treatment process themselves. The therapist and the child both suffered from results of such a premature termination. For the child, the termination symbolizes another loss and rejection which evoked anger. Often he/she did not feel comfortable in expressing this to the therapist whom he perceives as abandoning him. As a result, the anger was repressed and acted out later inappropriately and diffusely. For the therapist a premature termination evoked feelings of disappointment and frustration. In addition, the therapist was apt to experience a counter transference reaction of guilt and abandonment.

When the option of transferring a case was available, the reality based feelings of disappointment and frustration for the therapist were somewhat diminished. Counter transference issues could take the form of omnipotence, which would be destructive for the child's continuing treatment, if the therapist did not get adequate supervision around these issues. The child invariably reacts negatively to the idea of a "replacement therapist." This reaction was harder to work through if complicated by the therapist's own need to hold on, which hindered the child's need to move on and grow independently.

Coordination

In the treatment of children, it was essential to assess the child's total environment. Part of this assessment was determining what systems the child related to and how these systems made impact on the child. Some systems that were most frequently involved with the abused child were day care, foster care, crisis nursery, schools, camps, speech therapists, and residential treatment centers. These systems were assessed to determine the positive or negative impact they had on the child's growth, the extent of adjustment the child had within the system, and how the child's therapy could be integrated with these systems. These resources were also helpful in confirming or altering the hypothesis the social worker had about the child and in assessing the impact the therapy was having on the child.

During the treatment of the child, part of the function of the social worker was to refer the child to other resources that would compliment the child's growth and to insure that these resources were developed into a coordinated treatment effort. Very frequently, the abused child was as isolated as the parent, so that a major part of the treatment plan was to find outlets in which the child could experience as much positive adult and peer interaction as possible. Also, the evaluation of the abused child usually revealed that these children suffered from several developmental lags including problems in language, cognitive and motor skills, as well as in the emotional sphere. Because of this, it was usually impossible for any one person to meet all the needs of the child and therefore, essential that the social worker become familiar with as many service systems in the community as possible. Some of the resources used to provide increased stimulation and growth to the child were speech therapy, day care homes and centers, therapeutic day care, YMCA Camp, and other camps, wilderness experience , Big Brother and Big Sister programs, sports programs and extra curricular activities provided by the school.

While attempting to provide other services for abused children, the project social workers met resistance from two sources.. Initially, other agencies and institutions were resistant to providing services to abused children. Some agencies felt that the department of social services should have the sole responsibility for providing services to abused children. Other agencies primarily those who referred children to the Family Center for treatment, felt they had already exhausted their services to the child and felt so frustrated with the child's behavior that they wanted someone else to take over the responsibility.

Initial resistance also came from the parents of the abused children. The very isolated abusive parents often felt threathened by agencies attempting to provide services to their children. They saw this as an intrustion into their family life and feared that negative judgements would be made on their parenting capacity. Other abusive parents, primarily those that identified their children as bad or evil, felt that their children did not deserve help and were reluctant to allow other agencies to provide services to their children.

As a result of the initial resistance, the project social workers spent considerable amounts of time and energy working with other agencies and parents attempting to engage them in participating on a total treatment plan for the child.

Transference and Counter Transference

As with abusive parents, the issues of transference and counter transference often arose while treating abused children. These issues needed to be addressed during a child's therapy before significant progress could be made on the major themes of attachment, loss, anger, and self-esteem. The two most consistent transference feelings expressed by abused children toward the therapist included rage and idealization. The child expressed rage through behaviors that clearly indicated their need to re-enact the abusive relationship with their parents. These behaviors were non-verbal (hitting, spitting, biting) as well as verbal. The idealization occurred out of a child's terrifying fear of separation and loss. In this instance the child asked for gifts, favors, or anything that would help maintain the image of the therapist as an all-giving parent surrogate.

This rage and idealization stirred up many counter transference feelings for the therapist which were usually resolved through clinical supervision and consultation. As the child acted out his/her rage the therapist often experienced feelings of frustration, helplessness, anger and guilt. Whatever stage the therapy was in, it was important for the therapist to recognize the counter transference feelings and sometimes interpret them to the child. If this were not done the therapist played into the child's need to repeat the destructive relationship he/she had had with an abusive parent. If the child did hear and understand that the rage was not going to cause the therapist to reject or label him/her or as a bad child, he/she was then free to learn a new way of relating to adults.

The child's need to idealize the therapist often evoked corresponding counter transference feelings of over protectiveness. Extreme deference to the therapist's wishes, clinging behavior, and requesting gifts were often effective means of getting the therapist to protect a child. If the therapist did not reinforce the child's helplessness, the child could discover that the therapist cared about his growth as a responsible person.

Issues

The experience in treating abused children revealed several unique issues that needed to be addressed during the course of therapy. First, when parents did not also receive therapy, they often hindered the child's progress. Sometimes parents refused treatment because they denied any problems or if there was a problem, they attributed it to the abuse child. This usually set the child up for failure, since any success he achieved in therapy threatened to alter the pattern of scapegoating in the family. If parents would not participate in their child's therapy, treatment for the child may still have been recommended by the therapist and/or ordered by the court. This was done not only with the hope of providing therapeutic intervention for severe behavioral, emotional, or learning problems, but also with the hope that the parents could be engaged in therapy later. This was a gamble for the therapist to take, especially if the parents were heavily invested in defining their child as the problem.

Transportation was also an issue for treatment of children in situations where the parents did not participate in therapy. The therapists providing regular transportation to and from therapy often accentuated the child's idealization of the therapist, and the therapist's counter transference feelings for the child. Although arrangements such as these were not always therapeutic for children they nevertheless occurred because it was deemed necessary to treat children despite their parents lack of support.

In other instances where parents did not participate in their child's therapy because of relinquishment, abandonment, or the severence of parental rights, the child experienced the danger of being left without an advocate for treatment. Many agencies might have been involved for important reasons such as child protection or adoption, and those goals gradually took priority over the child's therapy. As previously mentioned in the section on establishing an alliance, it was extremely important for agencies that had a significant relationship with a child to cooperate in a treatment plan.

At the opposite end of this spectrum dealing with parents' participation in the child's therapy was the over involved parent and other family members could compete with the child for the therapist's attention. Because abusive parents often had some of the same nurturance needs that their children did, a therapist could find himself overwhelmed while treating the parents and the child. In this project it proved effective at times to assign different therapists to the parents and the child. Then the therapist did not get burned out by the overwhelming request for attention, and the parents did not get set up for failure by a situation which they might perceive as too competitive and rejecting.

A third issue in treatment of abused children concerned the importance of considering the child's total environment in the treatment plan. The project staff believed the most effective method of treatment addressed a plan that included not only the child's emotional growth and development within his nuclear family, but also tried to modify the total content in which the child functioned. As an example, one child's treatment plan included participation by a speech pathologist and a classroom teacher.

Chapter Nine

CRISIS NURSERY

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Introduction

One of the major children's treatment programs of the Family Center Project was the Crisis Nursery. When the project began there were no other crisis nurseries in the Denver area except for the one at the National Center for the Prevention and Treatment of Child Abuse and Neglect. Their program experience was very helpful in the designing and implementation of this project's Crisis Nursery.

Adams County had few choices in regard to placement resources for children and little treatment services for children at the time the project was created. The goal of this program was to provide child crisis care, evaluations, and treatment to abused children or "at risk" children. It was believed that parents would be more willing to engage in treatment for their problems if they had a resource for help with their children. Additionally, it was believed that, if children were placed during parental crises, fewer children would be abused.

Another goal of the Crisis Nursery Program was to document cost effectiveness of the program. It was believed that if crisis care and treatment were provided to children and parents, the need for long term placement would be reduced. It was hoped that if the nursery program was shown to be cost effective, then other counties, the state, or private agencies might utilize the experience and begin similar programs.

Programs of the nursery were flexible to meet the goals mentioned above. Specific objectives are listed below.

1. To provide staffing that would nurture the children, care for their medical needs, and provide individual remediation for the children's emotional and developmental lags.
2. To provide a nursery program that was "homelike" in environment.
3. To provide short-term care for children between the ages of birth through 12 who were abused or at risk for abuse.
4. To provide for parents a facility to voluntarily place their children when they were in a crisis which might result in an abusive incident.
5. To provide a facility and program where children could be placed while their parents were being assessed to determine the risks to the child.
6. To have the houseparents provide a proper model of parenting techniques for natural parents.
7. To provide evaluations of the children to determine their psychosocial and developmental needs.
8. To provide evaluative data throughout the project to determine the cost effectiveness of this type of care for children.

In subsequent sections the extent to which these goals were achieved will be discussed.

Criteria for Crisis Nursery Placement

When the Crisis Nursery began in February of 1975, the sponsoring agency administrators and the Family Center staff had defined the criteria for placing a child as follows:

I. The only child(ren) accepted will be "Potential abused child(ren)" or "abused child(ren)".

II. Only a child(ren) will be placed that is a new child abused case or an open child abuse case.

A. All placements at the Crisis Nursery will be made through a Family Learning Center Social Worker, the coordinator, or director. The Family Learning Center staff will secure a "beeper" and will be on call for placement considerations at the Crisis Nursery seven days/nights a week.

B. In placements of ongoing protective service cases, the ongoing worker will complete the necessary placement forms.

In the case of a placement made after regular work hours, the houseparents were authorized to complete voluntary admission forms, if necessary.

III. A child(ren) needing long-term placement will not be placed at the Crisis Nursery.

IV. Parents can voluntarily place their child(ren) at the Crisis Nursery.

The Crisis Nursery was certified by the State of Colorado as a receiving home, with the restriction of a sixty day placement. It was thought that sixty days was sufficient time to relieve a crisis situation and was perhaps long enough for behavior changes to occur.

Decisions regarding children placed in the nursery were initially made by either the director, coordinator, or social workers. The basis for this was because of the inexperience of the houseparents staff in working with child welfare services and families. As houseparents became trained and experienced with the program and the criteria they were involved in the decisions of placement for children. Thus, there was no need to have a beeper service available nor for staff to be on call to the nursery. The grantee agency developed a 24 hour on call crisis team for all social service needs and that team placed children through the houseparents.

In time, the original criteria was modified. Instead of leaving the decision of appropriate placement up to a Family Center Social Worker, the coordinator, director or supervisor, the houseparents were given greater control over that process, as their expertise grew. Referrals came directly from the Department of Social Services as well as from the Family Center staff, and rather than involve an auxilary person, the decision was left to those immediately involved; the family or child worker and the houseparents. The intention was to make the decision process more efficient and consistent for those involved.

Initially, there were to be meetings between the worker and the houseparents to discuss the appropriateness of a placement. This process was reduced to phone calls, the majority of the time, leaving meetings for cases when there were additional concerns after the initial call, over the appropriateness of the Crisis Nursery for the child and his/her needs. Inevitably, there were times when the placement worker and the houseparents disagreed. The houseparents' supervisor was an excellent source to bring insight or more incisive data to all involved due to his position, experience and educational background. The worker may have been more readily able to accept having his/her potential placement turned down. On the other hand, the supervisor may have agreed with the worker and helped clarify the issues involved with the houseparents.

At times, the children were admitted who did not meet the original criteria of the Crisis Nursery. During the summer, foster parents began taking vacations, and, if there were sufficient space in the Crisis Nursery, a child was placed for the duration of the foster parents' absence. Until or unless changes are made within the foster care system to incorporate foster children vacationing with their foster families, they will continue to be "lost" children. There simply were not any alternatives under the existing social services system.

Another change in criteria was using the Crisis Nursery for evaluation purposes, to determine whether or not a child should be returned home. The program accepted several children, who had a history of being abused or had been at "high risk", whose workers were unsure of the advisability of returning a child home. Their uncertainty involved the parents' ability to parent effectively and/or the level of interest a parent had for his/her child. The worker felt that the foster home setting was sometimes counterproductive to this evaluation process, primarily because of foster parents' unwillingness to allow the natural parents to visit.

A decision was made not to accept children in crisis if the parent and/or worker wanted a placement for less than 24 hours. The department of social services offered reimbursement of a baby-sitter's costs and day care facilities which were sufficient to meet a short-term crisis need. The staff agreed that every abusive parent should have access to time away from their children and that such services should be available in the county. However, that was not an appropriate part of the crisis nursery program.

To evaluate the appropriateness and to plan for the acceptance of a potential placement in the Crisis Nursery the following questions were asked of the worker:

(1) Can this placement wait a few days to prepare the child and the family? Or, does the child need immediate removal from the home?

(2) Has this child been abused or is there a high potential for abuse?

(3) How long does the worker anticipate the child will need this placement?

(4) Has this child been placed before? Where? For how long? If so, is this recurring abuse?

(5) Where does the worker anticipate the child will be cared for after the Crisis Nursery?

(6) Does this child have any behavior problems, physical handicaps, or medical problems?

(7) Would this child be a physical threat to a younger child or infant?

(8) Is this child excessively demanding?

(9) Does the worker intend to have the parents visit? If so, supervised or unsupervised? How often?

(10) What function can the Crisis Nursery serve that a receiving home, foster home, or day care home cannot?

(11) What strengths does the family have?

The Processes and Routine of the Crisis Nursery

The Crisis Nursery program was conceived to provide short term care, evaluation and treatment for abused children and children at risk, in coordination with the treatment of their parents. When the social worker and the houseparents of the Crisis Nursery identified the need for short-term placement of a child whose family was in crisis or it was thought that the Crisis Nursery could provide services to a child that a foster or receiving home could not, that child was placed in the Crisis Nursery for a maximum of 60 days. The Crisis Nursery setting provided a milieu in which treatment of the child and parents could be easily coordinated by the social worker and the houseparents, with the ultimate goal of reuniting the family, thus avoiding long-term foster care or residential treatment. There were exceptions, especially if a lengthened Crisis Nursery stay or an alternative to returning the child home was in the child's and/or family's best interest.

The first step in the Crisis Nursery process was accepting a child into it's program. Initially, the houseparents and the worker discussed the appropriateness of the potential placement. The houseparents considered the present Crisis Nursery population and other issues in determining whether or not they could be effective with that child.

If the worker and the houseparents agreed that the child was appropriate, a case plan was then devised or the existing case plan was shared with the houseparents. The case plan included: purpose of placement, length of stay, where the child would go after the Crisis Nursery, parental visitation, school enrollment, if outside treatment was desirable, and if there were any specific requests by the worker that the houseparents could fulfill, i.e., certain evaluations, behaviors to record or observe.

There was no rigid structuring of daily activities, but a level of consistency was provided to ensure security and confidence for the children. Each morning began with breakfast, followed by dressing and a period of free play. Children who awakened unusually early in the morning were instructed to find quiet activities to engage in until the houseparents awoke. Reading in bed, quiet play, or watching television were possible early morning activities. Children who attended school might play or watch television until time for them to leave. Pre-school children would play together in the playroom or outside without structure. The houseparents would observe this play and provide structure when it was appropriate. Children might be prompted to engage in particular activities and houseparents might engage children on a one-to-one basis for reading, game playing, or other types of interaction. A snack was provided at mid-morning, approximately 10:00 a.m., and unstructured play followed until lunch at approximately noon.

In the early afternoon the children and houseparents usually had a quiet time. The younger children took naps and older children looked at or read books quietly on their beds. This provided much needed rest for houseparents as well as exerting a calming effect on the children.

Afternoons were generally similar to mornings. Play continued with varying interaction with the houseparents. School age children would return home and play, watch educational television, or do school work. An afternoon snack was provided at approximately 2:00 p.m. In an effort to provide appropriate independence and encourage peer relationships, children were permitted to invite friends to visit at the nursery and to visit other children's homes. The houseparents requested that they know specifically where the child would be going, and specific times for returning were agreed. Most school age children enjoyed and were capable of having normal freedom to explore and interact with their neighborhood.

The evening meal was generally served between 5:30 and 6:00 p.m., and was followed by play and television watching. The houseparents were somewhat selective in choosing programs children were permitted to view, and children were not permitted to watch excessive amounts. With some groups of children, specific evening activities were organized such as the use of a Duso Kit, group discussions, or organized games. The houseparents felt it important, however, to allow the children a great deal of freedom to structure their own time and use their own initiative to plan activities, thereby fostering appropriate independence. An evening snack was provided and children had age-appropriate bedtimes.

Although special activities could not be planned for each day or each weekend, the houseparents did attempt to use the resources of the community to expose the children to new and interesting activities. Excursions outside of the Crisis Nursery were valuable for both the children and houseparents. Taking children out into the community helped negate the feeling of isolation. The excursions also benefitted the children by communicating to them that they were worth doing things for and with, thus enhancing their self-esteem. The Crisis Nursery had a small budget for petty cash which was used for financing activities and excursions.

Taking children on walks proved to be a simple and enjoyable activity. Walks provided a familiarization with the neighborhood and was good exercise for the children. Many of the walks taken from the Crisis Nursery led to parks where children could make use of more elaborate play equipment than was available at the nursery.

The houseparents made special efforts to engage the children in outdoor games that aided the development of gross motor skills and provided an excellent structure for learning group interaction skills. Swimming proved to be an activity most of the children at the nursery enjoyed greatly. Games such as baseball, kick ball, football, and bowling required the children to learn rules and apply them consistently, taking turns and sharing responsibilities. Children learned to deal with frustration, but achieved and experienced the rewards of playing a game well. Children experienced competitiveness, but the houseparents intervened to reduce the importance of winning. Small successes such as one good play were rewarded and all children were socially rewarded for participating.

The older children at the Crisis Nursery enjoyed going to movies. Attending movies and planaterium shows helped foster their ability to concentrate for a long period of time. The following other community resources were used and enjoyed: children museums, The Museum of Natural History, art museums, libraries, and the zoo.

Attempts were made to involve children in various every day activities of family life. These activities included visiting friends of the houseparents, taking shopping trips, running errands, and attending church functions. Additionally, eating in restaurants and going on picnics provided a relief from the routine and a learning experience for the children.

Most of the children in the nursery were too young to gain from outside activities. Thus, the houseparents rotated in taking older children on outings. Houseparents and children could leave the nursery for group functions, but phone coverage was important in the event of emergency placements. It was also desirable to notify natural parents when the nursery was to be vacant for a few hours.

Due to the fact that most children placed at the Crisis Nursery showed lags in educational skills and intellectual development, it was believed that children should continue to attend their previous school or be enrolled in the new school as soon as possible. School aged children were transported to their home school in an attempt to provide as much continuity as possible for the children. Especially in the case of short-term placements remaining in the same school eased the trauma of placement. If this procedure was impractical or impossible, due to distance and time, the children were enrolled in the public school closest to the Crisis Nursery.

A small number of children placed at the Crisis Nursery were attending therapeutic day care. The children remained in therapeutic day care during their placement since they would continue with therapeutic day care after they left the nursery.

Two sets of houseparents were on a rotation system. The rotation time was set for 5:30 p.m. every fourth day. Dinner was served and finished before the new houseparents came on duty. When they arrived, the children were asked to find suitable activities with which to occupy themselves, because the houseparents needed to be by themselves to share information. Both sets of houseparents were expected to spend at least an hour in this transition session. Such subjects as childrens' behaviors, parents' visits and any problems with the house were communicated. This transition time was necessary to establish consistency and coordinate each person's responsibilities.

Specific treatment methods often were implemented once a child was placed in the Crisis Nursery. These programs were tailored to meet individual needs. Usually these programs were of an informal nature. The houseparents were nurturing and consistent with discipline and rewards. Occasionally a child with more severe problems or needs was placed. Then a more formal and structured program was necessary. Both sets of houseparents gathered to discuss what behaviors needed to be dealt with and came to a consensus as to how it should be dealt with so treatment would be consistent. Basically, the houseparents were eclectic in their approach, attempting to provide services where and when they were needed, and to integrate those services into the daily routine.

Being with the child for 24 hour periods gave the houseparents a fairly accurate assessment of the child's needs and problems. This close proximity may have provided the houseparents with insight as to why the parent had difficulty with this particular child, and possibly some alternative coping mechanisms that could be effective for the parents. The houseparents were often empathic with the natural parents, letting them know this was a frustrating child to live with. Houseparents often modeled alternative and appropriate ways to deal with that frustration.

In addition to the houseparents informal assessments of the child, the project also had the means for formal evaluations. These included medical, psychological, and speech and hearing evaluations. The Family Center nurse was prepared to give a physical to each child. She also was available for periodic checks when a child was injured or ill. The Family Center nurse was the Crisis Nursery's primary medical resource although a doctor was occasionally consulted. Psychological tests were administered by a practicing psychiatrist or a clinical psychologist, depending on the child's age. The speech and hearing evaluations were completed by the University of Denver, Department of Speech and Audiology. All evaluations were helpful in attaining a complete picture of the child and his/her areas of strength and needs.

Research data was collected in the Crisis Nursery. The houseparents recorded demographic data, behavioral characteristics, length of stay, and evaluated each child's progress. The latter two areas were assessed via behavior forms completed periodically on each child (with the exceptions of infants and non-verbal children).

The goal of the Crisis Nursery was to provide quality, short-term care, treatment and evaluation of actual or potentially abused children. The houseparents drew from various resources to follow through with these goals. The houseparents provided a nurturing and consistent environment. They also attempted to modify inappropriate behaviors, as well as reinforcing appropriate behaviors. Statistical information provided a concrete measure of success or failure in the search for these goals, and noticeable improvements in a child were particularly rewarding.

Specific Programs for Children

Research, training, and experience led the houseparents to develop the expectation that children placed at the Crisis Nursery would exhibit several common needs. Children in abusive environments appear to lack what has been described as "basic trust." (Erickson) This basic trust develops as a sense of confidence that the world will meet the child's needs. It is the result of the child's experience of consistently being cared for and the experience of being adequately understood. (Benedek)

The abused, neglected, and potentially abused child has often not learned that he/she can look to others for help and that he/she is worth helping. (Kempe, Helfer) The abusive parent characteristically has high expectations for his/her child. These expectations often exceed the present capacity of the child to perform. Children placed at the Crisis Nursery also have often learned that survival may depend on meeting their parent's needs, at the expense of suppressing their own needs for parenting. It was the role of the Crisis Nursery houseparent to provide an environment in which the abused, neglected, or potentially abused child could learn appropriate methods of relating to people. They also provided a model of a consistent, nurturing, and non-abusive adult. It was also the role of the houseparents to provide an environment that would attend to the needs of the child and help foster childlike behavior in the children that were placed. With sensitivity to the special problems of the abused child and with an understanding of behavior patterns involved in a placement, the houseparents designed specific programs for fostering appropriate behaviors and extinguishing inappropriate behaviors. Before describing some of these programs, it would be helpful to describe patterns of behavior commonly observed in children placed at the Crisis Nursery.

Most children placed at the Crisis Nursery went through an initial phase the houseparents referred to as the "honeymoon period." This period of time consisted of the child's first interactions with the houseparents and other children at the nursery. The children manifested behavior during this time which could be broken down into two groups. The first type would exhibit very repressed behavior. In some cases these children were timid and shy and in the extreme cases, the children appeared to have a fixed gaze. Many of the younger children (ages 1-4) would exhibit this type of apprehensive behavior. This behavior could last for several days or extinguish within a few hours. This repression sometimes indicated the need for the houseparents to actively counteract the learned adaptive behavior of hiding and being non-verbal. In other cases, the experience of a consistent environment allowed the child to trust enough to give up repressed behavior patterns.

The second type of child exhibited little or no anxiety surrounding the placement. These children rushed into the nursery and immediately initiated play with other children. They showed no sign of stranger anxiety and actively engaged the houseparents in conversation or play, and often made statements to the effect that the nursery was a wonderful place to be and that the houseparents were such nice people. This type of behavior at the time of placement was visible in children of all ages and was particularly apparent in children who later showed poor ability to attach and a strong need to please the houseparents. Ravenous appetites and curiosity about the details of the Crisis Nursery routine were common as children sought assurance about the regularity and dependability with which their needs would be satisfied.

Following the "honeymoon period" the children went through a stage of adjusting to the Crisis Nursery routine. The child's behavior began to more closely approximate what was described as his/her normal behavior at home. The children began a phase of "testing" and attempted to ascertain the houseparent's limits and expectations. The children who entered the nursery with a desire to be overly helpful and friendly to the houseparents went through a period of confusion. They began to learn that the houseparents did not desire such a role reversal and often they were at a loss, due to a lack of any alternate method of relating to adults.

During this period of time, the houseparents evaluated the child's needs and determined what type of structure, behavior management, nurturing and discipline would best meet their needs. An additional benefit of having specific programs was to provide the houseparents with viable solutions to conflict. The anticipated length of the child's stay was an important factor involved in the decision to implement behavior management programs. For example, toilet training was rarely attempted due to the belief that sixty days was an insufficient length of time to develop a relationship that could produce a successful result. A list of behavioral, developmental, and nurturing problems that the children exhibited, and programs implemented to meet these needs immediately, follows this section.

The children placed at the Crisis Nursery did exhibit common characteristics; primary developmental lags; poor expressive and receptive language skills, and poor gross motor skills. They could not as a group, be easily categorized. Some children had severe emotional and physical problems, but these were the exception rather than the rule. The majority of the children placed at the nursery exhibited behaviors that would be considered within the normal range of childlike behaviors. The following list of needs and behavior problems were not seen as necessarily pathological, but were fairly common problems houseparents encountered while meeting the physical and emotional needs of these children.

1. Nurturing

Nearly all of the children placed at the Crisis Nursery showed signs of deficiencies in past parenting, with regard to basic nurturing. In an effort to meet this strong need, the houseparents attempted to be aware of nurturing needs and made consistent efforts to provide a warm and positive environment. This was accomplished in several ways. The child's basic needs for food, shelter, and clothing were met on a consistent basis. Three meals and three snacks were provided each day, with care given to nutritional needs. The Crisis Nursery provided shelter which was oriented toward children. An allowance of fifty dollars per child was provided for the purchase of clothing.

Beyond these basic needs, the houseparents worked to relate to the children in warm, affirmative ways. Infants were held more than the times necessary for basic care taking. Stimulation was provided to foster developmental progress in the areas of speech, fine motor skills, gross motor skills, and social interactions. Small children and infants were talked to and given attention, and when they attempted communication they were positively reinforced. Appropriate physical closeness was encouraged. Older children were encouraged to engage in conversation and their attempts to give and accept affection were also fostered. In general, children were made to feel that they would be treated with unconditional positive regard.

2. Enuresis, Encopresis

It was believed that problems of enuresis and encopresis in older age children was a symptom [illegible] emotional disturbance. The houseparents believed that during a short-term placement, it was inappropriate to make strong attempts to eliminate such problems. In most cases attempts were made to reduce stress and anxiety surrounding these difficulties. No punishments were used to extinguish these behaviors. However, the houseparents did require that children help in the tasks of cleaning and laundering wet and soiled bedding and clothing. Children who smeared feces were required to help in the scrubbing and cleaning. Bathing oneself was also a task children understood they were to do after each episode of wetting or soiling. These tasks were assigned with consideration given to the child's capabilities; children were not asked to clean or make beds beyond their capabilities to perform these tasks. The houseparents also employed the simple process of encouraging children with these problems to use the toilet at regular intervals and especially at night. Children were asked in a matter of fact way to participate in the cleanup process. Involving the children in this manner helped the houseparents deal with their own anger involved in cleaning up.

On two separate occasions, the houseparents did implement behavior control programs for the purpose of extinguishing bedwetting. With one group of three boys, ranging in age from five to ten years, the privilege of having a special colored blanket was awarded for each dry night. In a second case involving a twelve year old girl, small rewards were offered for a series of dry nights. This program was a continuation of past work with the child's problem and there was agreement that some structure would continue after she left the Crisis Nursery. The program was implemented with the understanding the child was invested in changing that behavior. The houseparents felt it was most important not to become involved in a struggle with children surrounding these issues, because these children exhibited emotional conditions that could not be altered during their short stay in the nursery. Avoiding control battles where there was a win/lose situation was important. Instead of getting involved in the struggles, the houseparents dealt with the reality of having to clean up afterwards.

3. Excessive Crying, Whining

In an attempt to eliminate these problems, children who exhibited whiney behavior and an excessive amount of crying were encouraged in every way possible to use alternate methods of communication.

Children were never rewarded for inappropriate crying or whining. Whiney requests were ignored or the child was told that he/she must use some form of less irritating communication. The houseparents employed heavy prompting at first, such as, "Can you tell me what you want, rather than cry or whine?". The prompts were initially very specific and gradually the children were required to do more of the formulation of their questions. If the child seemed unable to indicate or verbalize what need he/she was experiencing, an effort was made to model such communication. In several cases where crying and whining was the child's mode for all communication, it was necessary to take the child to his/her room. This was done with a statement such as, "We don't like to hear your crying, you may come out of your room when you choose to stop or tell us what you want." After such an episode, the child would be given verbal rewards when crying stopped and encouraged to communicate what need initiated the crying. All non-whiney communication was consistently rewarded.

4. Timidity, Passivity and Shyness

Children who were inappropriately timid or passive were exposed to an environment in which it was rewarding to be more assertive. It was the houseparents' belief that many of the children's timid and passive behaviors were adaptive survival behaviors in their previous environments. Many children in abusive situations learn that it is safer to be quiet and unobtrusive than assertive and alert. These children have learned that it is not "o.k." to have feelings. When the children had feelings they were taught not to express them if they conflicted with the feelings of their parents. The passivity and timidity may be the result of these repressed feelings. An unobtrusive child is less likely to be abused. Attempts were made by the houseparents to reward timid, shy children for any efforts to communicate. One goal was to get non-verbal children to substitute words for gestures and to get preverbal children to use gestures. The houseparents would not "rescue" these children by doing their communicating for them. For example, if it were snack time and an inappropriately passive child were to enter the kitchen and look longingly at the bowl of fruit, the houseparent would not provide the child with the necessary communication, i.e., houseparents would not say "would you like your snack now?" The child would be required to take an active part in the communication. He/she would have to attract the houseparents' attention and then verbalize or gesture what he/she desired. It is imperative that once a child with this problem communicates, that houseparents reward this behavior by attending, but it is equally important that the child learn that passive behavior will not provide rewards or get needs met.

A second type of problem involves acts of aggression by other children against passive children. The houseparents method of dealing with this problem was simply to require the child to assert and protect himself/herself. This could become very difficult to tolerate as some children would succumb to much punishment from other children, cry and scream for a long period of time before they would assert themselves. The houseparents would not allow a small child to be injured by an older, more powerful child. However, to help the passive child develop assertiveness, it was necessary that the houseparents not save children from situations in which they were capable of saving themselves.

This required that a houseparent define the difference between a passive child and a masochistic child. This determination was subjective and based on a number of factors which included the child's affect during abuse by other children, aggressiveness, provocativeness, and use of possible avenues for escape.

5. Aggressive Behavior, Acting Out, Distruptive Behavior, Deliberate Rule Breaking, Hyperactive Behavior

These are all provocative behaviors and thus, were dealt with in similar ways. During the first few days of placement, the houseparents were careful to explain and describe all rules and restrictions regarding the house, play and interactions. Of course, the rules were age dependent and the younger children learned what could not be tolerated primarily by trail and error. There were few basic rules concerning behavior. Children were not allowed to physically harm themselves or others. They were required to ask before getting into cabinets, or other children's possessions. Food was to be taken only with permission. During play, they were asked to stay on the Family Center premises unless given permission to leave. Children were told that they would take a nap, or have quiet time, and that bedtimes would be decided by the houseparents. Such behaviors as smoking and bad language were also discouraged. When these rules were broken or when a child engaged in activities that were inappropriately aggressive, the most often used method of behavior control employed by the houseparents was to send the children to their room for a specific length of time. (Patterson) If inappropriate behavior continued during this time-out, extra minutes would be added to the time-out period. The houseparents communicated the fact that the child would be permitted to stay in time-out as long as he/she wished, and continued disruptive behavior indicated that the child wished a longer time-out. This was not necessarily done as a punishment, but rather as a way of eliminating external stimuli that the child was not able to respond appropriately to at that time.

In some instances of destructiveness, time-outs might be used in conjunction with having the child repair whatever had been destroyed. At the end of such time-outs, the children would be told that the houseparents were glad that they were now ready to come out and rejoin the nursery activities. Children with these problems would be consistently rewarded socially and verbally for appropriate behavior, such as attending to a task or game for an increasing length of time, sharing, helping, and engaging in appropriately quiet behavior.

These children also received rewards for a more direct confrontation with people with whom they were angry. The houseparents were not trying to discourage their feelings or stifle the children, but rather to help the children to more appropriately express these angry feelings.

With one group of boys (ages 5-9), the houseparents implemented a program whereby rewards in the form of a happy face on a chart could be earned for good behavior during certain parts of each day. The charts contained blank spaces which could be filled in with a sad face or a happy face depending on the child's behavior. After each time period, the child and houseparents would discuss how that time had gone and reach an agreement on the "face" to be given; at the end of these discussions, the houseparents would ask the child, "how could you have earned a happy face?" And this question was also discussed. At the end of each week, children who had earned enough happy faces were rewarded by being taken out for a special activity, such as a movie, swimming, trip to the zoo, etc. The immediate gratification of praise and the delayed reward of a special activity proved to be an effective incentive for good behavior, as well as an aid in getting the child to talk about and learn what would be more appropriate behavior.

6. Lying

Children who have a problem with lying on a consistent basis have the potential of engaging houseparents in difficult and unrewarding struggles. The houseparents arrived at the conclusion that the most effective method of dealing with children who lie was not allowing them the opportunities to lie. Such questions as, "did you break this rule?", would in reality constitute a set-up for the child who lied. Instead of asking questions that require the child to admit guilt, it was found to be best to simply confront the child and say, "I believe you broke this rule and you know what the consequences of your behavior are." In most cases, when a child was confronted in this way, he did not lie, but when he/she was asked to admit guilt without knowledge of the consequences of such an admission, the child chose to lie. This method of dealing with the child who had a lying problem limited the amount of struggle involved and avoided the situation of houseparents feeling a need to secure an admission of guilt for misbehavior.

7. Role Reversal, Age Appropriateness, Inappropriate Sexual Advances

A side effect of abusive parent's dependency on children to meet their needs is the child's development of the attitude that it is desirable to and sometimes necessary to parent adults. Several children placed at the Crisis Nursery had strong needs to parent the houseparents and other children. An aspect of this inappropriate parenting was the child's desire to behave as an adult, socially and/or sexually. As an illustration, a nine year old girl placed at the nursery exhibited strong needs to parent and be adultlike. L. was extremely solicitous and asked consistently to help with the houseparents' domestic tasks. She showed no interest in age appropriate play unless it involved playing the role of an adult. She would approach a male houseparent when he was preparing to change an infant's diaper and say, "Here, that's something I should do." L. was placed in the Crisis Nursery with two younger brothers (ages 5 years and 7 years) whom she referred to as "her babies". L. also gave the houseparents advice and instruction with regard to parenting. On one occasion, she was found in bed with a twelve year old boy and when asked what was going on, she said she "just wanted to be with her boyfriend". This was a more extreme case, but her behavior was typical of children with the problem of inappropriate parenting. The houseparents worked with this child and other such children on learning to be a child. L. was allowed to help with housework, but on a limited basis, and was discouraged from asking to do things for the houseparents. She was also not permitted to parent her siblings or other children and when L. attempted this inappropriate parenting, she was verbally told to stop and alternative behaviors were suggested. She was consistently given the clear message that she was a child and the houseparents were adults and the appropriate differences in responsibility and behavior were pointed out. L. was encouraged and helped to discover and enjoy children's games and play. In general, children with needs similar to hers were treated by discouraging inappropriate adult behaviors and parenting. Appropriate childlike behaviors were rewarded and encouraged.

8. Power Struggles

In dealing with power struggle problems, the houseparents avoided involvement in such struggles. Children were disciplined in a consistent, matter-of-fact way. The awareness of the child's attempts to involve the houseparent in a struggle allowed the houseparent to avoid confrontation. Maintaining a calm and controlled attitude communicated to the children that stubborness would have no "pay off" and their attempts at creating struggles would be in vain. Accordingly, some behaviors that were thought to be struggle issues for the child, were deliberately ignored by the houseparents, unless it was a potentially harmful behavior.

9. Self-Esteem

The houseparents made attempts to foster self-esteem in all children by providing a nurturing, affirmative environment referred to earlier and the use of praise for appropriate behavior. For example, while engaged with her mother, one child was asked to perform many difficult tasks and errors were criticized while successes were ignored by the mother. In contrast to this, the houseparents employed the method of giving generous praise for successes and ignored or uncritically corrected errors. Periodically, the houseparents made a point of praising children with low self-esteem by saying that he/she was a "neat kid" or a similar type of statement, for the purpose of communicating to the child that he/she was someone worth caring about and of value.

10. Denial of Feelings

In some abusive situations, children learn that it is best to deny feelings. The denial of discomfort and pain serves as a defense mechanism and makes the child less irritating to his/her parents, but denial may sometimes be physically dangerous. The houseparents attempted to help children recognize their feelings whenever possible. Prompting such as, "I'll bet that really hurt", or "I'm sure that made you angry", was used to begin the process. As a child showed progress, the prompting would become less specific and a question such as, "how did that make you feel?" might be asked. Finally, it was important that the houseparent attend to and reward the children's communication of feelings. Each time a child would communicate some feelings, the houseparents made efforts to respond to and explore those feelings.

11. Provocative Behavior

The phrase "setting up" came to describe children who had learned to place themselves in situations or act in behavior patterns that would result in their being punished. Children who learned that their appropriate good behavior will be ignored and that parents will give attention for misbehavior, developed this irritating method of interaction. In dealing with this problem the houseparents might simply ignore some inappropriate behavior or discipline in a matter-of-fact, unconcerned manner. This was accompained by a statement such as, "you don't need to do ..... to get our attention. If you would like us for anything, you can tell us." Discipline consisted of removal from interaction by being placed in their room for a specified period of time. It was felt that if the child experienced a parent who would not give a high degree of attention to inappropriate behaviors and that if such behavior would result in a separation rather than an acceleration of attention, then the "setting up" would extinquish.

12. Family Relations

Many of the children placed at the Crisis Nursery were involved in unresolved familial struggles. It was very important for the houseparents to deal with these children's feelings, i.e., confusion, anger, fantasies, separation trauma. In this process, it was imperative that the houseparents maintain as high a level of objectivity as possible. Any indication that the houseparents felt contempt for a child's parents would have been extremely detrimental to that child's return home. The children needed to express their feelings and were urged to communicate feelings to their parents. Houseparents operated in the precarious position of being the child's advocate as well as being involved with parents on an ongoing basis. Helping children explore their feelings related to family and helping the children reach some resolution was a necessary task for houseparents to undertake with children who manifest unresolved familial struggles. However, this was often a more difficult objective to achieve than sixty days would permit. At times unresolved familial problems blocked all attempts to work on other problems and children who continued to suffer from family problems showed little or no progress during this short-term placement. Visits between child and parents did allow opportunities for the child to work through some of these struggles and for a time of reality testing.

13. Dependence - Independence

Children whose parents had not allowed then to develop appropriate independence were difficult for houseparents. These children were typically very demanding and often constantly "under foot". In dealing with these children, the houseparents attempted to foster independence by rewarding children for attempts to expand their capacities and explore new behaviors and situations, but not to the exclusion of appropriate dependence. The houseparents learned that these children must not be "saved" from the consequences of their behavior. Too often in these children's past, they had been overprotected. Typically, a houseparent might respond to a child's inappropriate request for help with, "that is something you can do yourself - you can learn to do that." The houseparent then assisted the child to learn this behavior through prompting or modeling. It was important, that expectations did not exceed capabilities. The following is an example of how the houseparents approached this problem. One child, T., age two, had been separated from his mother only once prior to the nursery placement and for not more than a few hours. T. displayed an inappropriate degree of dependence on her. The other children in the Crisis Nursery quickly learned that T. would not retaliate when bullied, so he became the target of much harassment. T.'s reaction to this was to stand or fall on the ground and cry and scream with a great deal of enthusiasm. The houseparents found this difficult to listen to and it was a long time before this behavior extinguished. But with consistent encouragement, T. began to retaliate and rescue himself. As T.'s behavior began to become more independent, he was "picked on" less and became a more enjoyable child.

In some cases, a child exhibited inappropriate independence. This usually manifested itself in the form of not asking for help when it was needed or simply not bothering to communicate needs. This behavior was dealt with by fostering communication, attending and responding consistently when such a child attempted to ask for help, the use of prompting to help a child form a request, and the avoidance of "saving" a child by helping them meet needs without requiring any participation on their part.

14. Depression

It was not uncommon for children placed at the Crisis Nursery (following moderate to severe abuse) to be in a state of depression. The intensity of the depression varied from mild to near complete inactivity and withdrawal. This depression was often an appropriate response to trauma and stress. It was not the houseparents' role to suppress the depression, but rather help the child realize the source of the depression and what steps might be taken to resolve it. A houseparent might help a child get in touch with his/her feeling with prompting such as, "it's pretty scary being here, isn't it?". The children were told that it was "o.k." to feel lonely, sad, scared, and anxious, but they were also reassured that they would be taken care of at all times and that they were safe at the Crisis Nursery. Of course, the ability of the child to realize the cause of his/her depression and explore those feelings was age dependent. With older children, dialogue was useful; with preverbal and immature children, physical comfort and holding in conjunction with basic nurturing was most helpful. Very few children maintained a state of depression for more than a few days when helped through the depression; however, houseparents did expect recurring depression due to unresolved problems and the insecurity of being in foster care without knowing what would happen next.

15. Developmental Lags

A very high percentage of the children placed at the Crisis Nursery tested below the normal range of development. The needs of the children varied and a great number of specific programs were designed to meet special learning needs. The houseparents constantly made efforts to foster language by engaging the children in conversation, reading to them, encouraging them to play games that required the use of language. Children were encouraged to play games that would promote the development of gross motor skills, and for infants, stimulation was provided to aid development. The playroom was equipped with toys that could help foster development both physically and mentally. Educational television (Sesame Street, Electric Co., Mister Rogers, and Zoom) was also used as a resource. In general, the nursery program attempted to be aware of developmental needs and deficiencies and used this awareness to implement structures that could promote development.

16. Sleeping Problems

It would be expected that children coming to the Crisis Nursery from different environments and situations would have developed different sleeping patterns. Children at the Crisis Nursery verified this expectation. Children's need for sleep varied from five to six hours to 10 to 12 hours a night. The majority of toddler age children and older slept less than 8 hours a night at the nursery. The necessary structure of a Crisis Nursery dictated consistent bed times, these children were required to go to bed at specified times. Appropriate behavior at bedtime was rewarded by the privilege of taking a stuffed animal or doll to bed. Misbehavior at bedtime would result in an earlier bedtime the next evening. The houseparents found it desirable to rotate the task of getting up first in the morning. This rotation was limited by the nature of the children; infants and a particularly demanding group of children might make the rotation of mornings to get up impossible. In contrast to the children who slept very little, there was a small number of children who slept a large amount of time. These children seemed to be using sleep as an avoidance activity to escape reality. It became necessary with these children to limit sleep by engaging them in activities and by making special efforts to raise their interests in appropriate activities.

17. Eating Problems

In the first days of placement, many children appeared to have insatiable appetites. Children who came from situations where food was not available or where needs for nurturance in general were not met, experienced the desire to overeat. This overeating extinguished as the children experienced consistent feeding, but it was not unusual for the houseparents to find children hiding food in their rooms and sneaking into the kitchen at night.

For some other children, eating and mealtimes were struggles. These children might refuse to eat some or all foods. The houseparents' position on this issue was to not force a child to eat, but rather make eating desirable. Cultural differences were taken into consideration as attempts were made to find foods that the children would enjoy and wish to eat. When a child chose not to eat, he/she was not punished, but the privilege of having dessert or a snack would be removed. That is, if a child chose not to finish a meal, he/she understood that dessert would not be served. This program proved to be successful in avoiding struggles around food and gave the child the opportunity to make his/her own decision regarding what he/she wished to eat.

18. Accident Prone Behaviors

Many of the Crisis Nursery children were unusually accident prone, as was reflected in the overall low achievement on measurements of gross motor skills. This was probably due to a highly anxious, guarded view of their world which prevented them from exploring the limits of their physical universe and impaired their spatial perceptions.

In attempting to help the children resolve this problem, houseparents were careful to control their reactions after accidents by acknowledging pain in the child while avoiding the offer of reinforcement for getting hurt. In cases of forseeable and genuine dangers, houseparents sometimes warned children and offered suggestions for ways of preventing accidents. The most important accident prevention techniques involved the houseparent staff encouraging a variety of gross motor activities in relatively safe environments that allowed the child to run, jump, and fall in the process of remediating perceptual deficiencies.

19. Failure to Thrive

Several infants and toddlers were placed at the Crisis Nursery with a diagnosis of "failure to thrive" and houseparents were asked to help determine whether or not it was due to caloric deprivation. This process entailed weighing the child at a specific time each day and feeding the child a diet appropriate to his age. When a consistent weight gain of at least 1 ounce per day was made and documented, failure to thrive due to caloric deprivation was assumed. Two children ate well and did not gain. Failure to thrive due to emotional deprivation seemed to be the cause of this failure to gain in these children who seemed withdrawn and depressed.

20. General Medical Problems

The incidence of health problems among children in the Crisis Nursery was quite high. Even children who ate and slept well experienced more than the expected number of ear infections, diarrhea, dermatitis traceable to vitamin deficiences; and borderline anemia. It was the opinion of the project nurse that if this general poor health persisted after the child received good nutrition it was probably due to the child's unhappy and highly anxious state.

Beyond seeking and following medical advice, the houseparents could do little more for these children than provide stimulation and regular nutritionally adequate meals; see that the children received plenty of sleep; and try to help them stabilize emotionally as quickly as possible.

Over the 26 months of Crisis Nursery operation, the houseparents were impressed with the changes that children made when provided a reasonable consistent, safe, and nurturing enviornment. Some children denied feelings, parented adults, or were extremely passive and in a few weeks became appropriately assertive, curious, and enjoyable. Children who were alleged to have been fire-setters and generally were provocative in the natural home did become cooperative and reasonably controlled in the nursery setting. Houseparents came to realize that with time, consistency, and hard work, most behaviors could be positively affected.

It was important to remember, however, that the behaviors considered inappropriate in the Crisis Nursery were often the adaptive and reactive behaviors that had permitted survival in the natural home. Whenever possible, a parent was asked which specific behaviors of their child were most intolerable. Many times the responses were not accurate in terms of the child's behavior nor realistic in terms of his/her stage of development. When appropriate, houseparents worked to extinguish the targeted behavior, thereby making the child more attractive and potentially increasing parental investment in the treatment process. It was imperative that social workers be sufficiently aware of the family situation to provide regular and complete information to houseparents.

One helpful message given to older children was that "people do things differently. When you are with me, these are ways in which you can behave." This was an attempt to help the child discriminate between actions that were appropriate with houseparents and with their own parents. This was extremely important for the child's future relationships and it was hoped this learning to discriminate would help insure his/her safety at home.

As soon as the family worker gave approval for parental visits with the children, visits were encouraged by the houseparents. These visits resulted in fluctuations in the children's behavioral and emotional status. A child whose parent or parents were not visiting would begin to ask "When will I see mom and dad again?".

As the sixty day limit approached, the children began to ask if they would be returning home or moving to some other form of foster care. The houseparents believed it was necessary to deal with these questions honestly and in a straight forward manner. Children were more capable of dealing with realities than false hopes or avoidance. Often the houseparents simply did not know the answers to the children's questions. A response such as, "I don't know where you will be going when you leave here, but where ever it is, you will be well taken care of," was acceptable and somewhat reassuring to children. It was important that lines of communication between the houseparents and the social worker be open and maintained so that the houseparents could be adequately prepared to answer children's questions with as much information as was available.

The houseparents believed it was necessary to let the children know and understand at the outset that their stay at the nursery was temporary. Children were not permitted to call the houseparents "mom" or "dad"; first names were used. This avoided misunderstandings around the role of the houseparents for both the children and the parents. The consequence of this policy was that children experienced occasional feelings of insecurity, but the time for termination did not arrive as a surprise. The temporary aspects of placement in the Crisis Nursery were always presented clearly to natural parents and the children. This was done to avoid feelings of rejection at termination, to discourage inappropriate fantasies about being saved by the houseparents, and to place an emphasis on the objective of returning the child home or moving a child to a more stable environment.

The process of termination varied greatly for the children placed at the Crisis Nursery. Children placed for very short periods of time felt little or no anxiety about leaving. Some children were very happy to be returning home and others exhibited signs of anxiety surrounding a return home or a move to long-term foster care. These anxious feelings were appropriate and the houseparents explored them with the children.

Once it was determined where a child was going following a Crisis Nursery placement, a meeting was arranged for the child with the significant adults in the child's life. This meeting included houseparents, parents, and social worker. The appropriateness of the parents' attendance was dependent on the type of move the child was making, and the appropriateness of the social worker attending was dependent on the extent of his/her involvement with the child. It was important that the houseparents communicated clearly to the child that his/her being moved was not the result of any wrongdoing on his/her part. The houseparents anticipated the child's feelings of rejection and made efforts to deal with those feelings. Houseparents expected a period of regression and "acting out" behavior following a child's realization that he/she would be leaving the Crisis Nursery. During the period of termination, children would often reject friends made at the nursery, as well as the houseparents. Efforts were made to help children work through their feelings of rejection and express true feelings of relief and/or grief over leaving the nursery.

The houseparents also dealt with their feeling toward the departing child. Termination with some children resulted in a sense of relief for the houseparents. Houseparents needed to be aware that this was not an inappropriate feeling so that they avoided guilt associated in terminating with an extremely difficult or unlikeable child. Houseparents also felt a real loss when children with whom they had felt a strong attachment left the program.

Children's Attitudes Towards Natural Parents

Children in the Crisis Nursery generally held strong emotional attachments to their natural parents. This was evidenced by the degree of separation anxiety experienced; persistent requests for visists and telephone calls; the wistful desires to go home; and the general excitement surrounding parental visits to the nursery.

The degree of attachment to the abuser appeared to be largely unrelated to the severity of abuse. The length of time involved in both the abusive situation and the placement, and whether or not the abuser was a primary caretaker or a new person in the child's environment may have influenced the degree of attachment the child displayed.

Most of the verbal children avoided comment about the abuse incident; invented stories of improbable accidents to explain injuries; worried about the consequences of the abuse incident for their parents; made excuses for their parent's actions; or accepted responsibility for the abuse on the basis of their own "bad" behavior.

Some children did ignore or act out their hostile feelings toward visiting parents. Typically, these children were younger, pre-verbal, or emotionally immature. Older children seemed to be more involved in taking care of their parents or just genuinely glad to see them. Generally, the older children were less aware of their anger at their parents than the younger children. Although some parents could verbalize that their child had a right to be angry, they usually required some help from their social worker or therapist in dealing with the pain and guilt the child's anger aroused.

The incidence of acting out behaviors typically rose sharply during parental visits as the child sought to balance the experience in the Crisis Nursery with that of the natural home, or was simply caught in the old interactional patterns with his parents. Overnight and weekend visits could result in what appeared to be almost total regression. These behaviors usually diminished with frequent visitation, as the parent learned more appropriate management skills and/or the child made progress in expressing feelings. The successful resolution of this conflict was an important part of the work for both parent and child, and an inability to attain such a resolution indicated a need to consider alternatives other than placement back in the home.

Houseparent's Attachment to Children

Disliking a child in placement proved to be a hurdle that was initially difficult for each houseparent, but inevitable in terms of the numbers and types of children placed in the crisis nursery. Frequently, such antipathy was attached to physical appearance or specific annoying behaviors, and the child became more acceptable as changes were made in either regard. At other times, however, dislike was associated with nothing more substantial than individual preference, and the most effective means of coping with the problem was to arrange for the primary responsibility of the child to be assumed by the member of the houseparent couple who felt less negatively. This permitted houseparents to interact with specific children when they felt enough control and tolerance to offer positive input. Other houseparents and supervisory staff were useful for testing the reality of one's image of the child, and provided support in working through these feelings.

One point which cannot be overemphasized is the need for houseparent, supervisory, and social work staff to achieve some comfort with the fact that none of them can like every child that is placed. This fact need not diminish the quality of care a child receives, nor necessitate placement at another facility. It does serve to relieve an unrealistic pressure on houseparents to like all children, and permits the child to receive positive input with a minimum of destructive mixed messages.

The issues of the likeable child were equally problematic to houseparents. Coupling the emotional investment required for the position with a natural attraction to specific children resulted in the formation of strong reciprocal attachments between houseparents and children. Particularly with the child whose parents were totally uninvolved, the houseparents struggled more with the issues of emotional over-involvement with the children.

These attachments were generally viewed positively as promoting growth and security for the child, while providing emotional reward for the houseparents.

Attempts to prevent such attachment could have resulted in a callousness that would render houseparents ineffective in caring for the children. Safeguards built into the Crisis Nursery process provided a reality base for these relationships. These safeguards were:

1.) Whenever possible, natural parents were encouraged to visit frequently. As houseparents broadened their investment to include all family members, perspective was more easily maintained.

2.) The four day on/off scheduling of houseparent staff did not permit any one houseparent to assume primary responsibility for any one child. Sharing that responsibility provided a constant reminder of the reality that the houseparent/child relationship was temporary and non-exclusive.

None of these safeguards, however, diminished the feelings of attachment, and there was a need for an appropriate grieving process when a favored child left. Particularly when houseparents thought the natural home environment was less than adequate, the pain that houseparents felt was great. During these times, the support of fellow staff and supervisors was important.

Houseparent - Natural Parent Interactions

At the outset, the houseparents' function was seen almost exclusively as providing care for the child and helping natural parents to "feel comfortable" during scheduled visits in the nursery. However, as both houseparent and social work staff gained confidence in the operations of the nursery, the concept of appropriate houseparent/natural parent interaction began to grow.

Visitation between natural parents and their children was arranged by the houseparent staff on a schedule considered appropriate by the social worker involved with the family. Except when the purpose of nursery placement was to evaluate parental investment, this visitation was actively encouraged by the houseparent staff. Typically, visits initially took place in the nursery several times a week, and increased in frequency as the family situation stabilized.

By taking into consideration the time of day and each child's normal stress times, the houseparent staff was able to structure relatively nonstressful initial visits, and gradually allow parents to assume responsibility for more direct care of their children. Thus, a parent who came first in the midafternoon to play with his/her child for an hour, would later come at dinnertime to feed and bathe the child and put him/her to bed. This structuring was seen as valuable for its effect of building positive experiences and a feeling of competence in the parent. It also minimized destructive failure cycles and allowed modeling. Further, it permitted the child to interact in a more positive manner with their parents.

Some parents who called and visited frequently spent their time engaging houseparents in discussions and were unable to relate to their children. When this problem persisted despite houseparent efforts to restructure the visits, the social worker was advised and considered this in his/her decision about whether or not a parent could cope with the children's return home.

As part of this process, parents would begin to take their child out of the nursery for visits of a few hours, overnights, and finally a few days at a time. By considering the effect of the visits on both parent and child, nursery staff could identify serious problems before the child was actually returned home. One of the risks involved with this process is that parents may leave the community with their children. However, this only occurred in two out of 121 cases.

It was not seen as useful to have any "settling in" period before permitting parents to visit their children. When children were not allowed early visitation because of parental circumstances, fantasies of parent death and feelings of anger could not be resolved. Also, early intervention with parents seemed helpful to them. When initial visits were postponed either by workers or parents for several days or weeks, it was difficult for the parents to engage in an alliance with the houseparents and to accept the reality of their children's separation from them. Being accepted without judgment during their worst and hardest moments freed parents to be more open and address their real concerns and issues around the child more honestly. Acceptance also reduced the chances of parents denying that certain problem behaviors of their children existed in his/her own home, and helped the staff get a truer picture of the continuum of parent/child behavior. The houseparents were the least threatening member of the treatment team to the parents because they did not have the decision making authority over placement visitation and court action.

One important step in successful interactions with natural parents was getting past the problem of being seen as the "expert", "ideal parents", or judges of the behavior of the natural parent. Although it was important to let a parent know when he/she was behaving appropriately in relation to the child, it would have been inappropriate for the houseparents to lavish praise on the parent. Such praise would have had the effect of placing the houseparent in a superior position in relation to the natural parent and increased the opportunity for sabotage of the treatment program.

At first, houseparents used numerous ways to give parents appropriate reinforcement for positive interaction with their children. These included a smile, repeating the parents' praise of the child, and acknowledging of their parenting ability in dealing with difficult behaviors. As time progressed, parent's became able to deal with their children's behavior without the need for external reinforcement. This occurred in part because the children became less difficult to deal with and because the parents were encouraged to use all their positive parenting ability and knowledge of their individual children's needs. At first this meant involving parents in such simple need areas as type of clothes the children needed, food preferences, and hair styles. As they understood their children more fully, this included input about complex emotional needs.

Because consistency was of utmost importance in dealing with the children, it was necessary that inappropriate behaviors be confronted during parental visits, either by natural parents, or by houseparent staff. Appropriate behaviors were praised by houseparents in the hope that the natural parents would imitate and gradually internalize positive methods of behavior management. Modeling the houseparent's behaviors became an important part of the treatment plans with natural parents. As parenting skills sharpened, parents gradually resumed more of the primary care for their children during nursery visits.

Houseparents discussed behavioral management issues, basic infant and child care, nutrition and feeding problems, normal child development, and alternative coping mechanisms with natural parents.

Several general postures were found to be important and helpful in dealing with natural parents. Houseparents needed to remember, reflect, and integrate the attitude that children were not being "saved" from their natural parents. The houseparent's ability to view all family members with positive regard was a helpful factor in the eventual reintegration of the family unit. Inevitably, this meant that houseparents needed to have addressed their own issues regarding people who abuse their children.

Since even unverbalized houseparent attitudes regarding whether or not natural parents were able to care for their children could set up destructive tangential interactions, it was critical to withhold initial judgment on the issue until such a judgment could be based on objective fact (quantity and quality of visits). Working closely with the social worker involved with the parents was especially important in determining appropriate responses when issues of relinquishment and termination of parental rights were in question.

Generally, the paraprofessional houseparent staff with the support of professional supervision and in cooperation with social work staff was successful in working with abusive parents around the issues of children and family interaction. In cases where the parents were receiving individual therapy from their social worker, houseparent staff was used effectively to cultivate central basic skills in child management, growth, and development.

The Environment: The Physical Nature of the Crisis Nursery

In the search for a suitable building to house the Family Center, the staff felt it would be optimal to have the Crisis Nursery and other staff in close proximity. The reality was that funding permitted the rental of only one facility for all the project's programs. The staff sought a home facility, rather than an institutional-appearing facility and an older, two story house was secured. There was sufficient room for offices on the second floor and enough space for a Crisis Nursery on the first level. An outer staircase served as the staff's entrance to the upper level, preventing use of the Crisis Nursery as a pass-through.

Many renovations were made to prepare for the house's new function as a Family Center. Volunteer groups were recruited and provided the needed manpower and much of the materials. After the renovations were completed, an "open house" was held. The "open house" served a dual purpose. First, it familiarized the community with the Family Center. The purpose of the Family Center was not to remain aloof, but to become involved in it's community. Therefore, it was extremely important that the community feel comfortable with it's new neighbor. Secondly, the "open house" was a means of expressing appreciation to all those who had volunteered their time and efforts.

The Crisis Nursery consisted of the ground level and basement of the house. By having the rest of the staff so readily available to the houseparents, they felt much more a part of the total project effort than typical foster parents might. The houseparents were included in the weekly staff meeting and were well informed as to inservices at the grantee agency, the Adams County Department of Social Services.

The ground floor of the Crisis Nursery had three bedrooms, a kitchen, bathroom, living room, and playroom. The basement was used primarily for storage and housed the washer, dryer, and freezer. The Family Center was located on a large lot which was divided between parking spaces and yard for play. The play area was completely fenced. There were tricycles, small wagons, a sandbox, swings, and a jungle gym for the children to play with outside.

The two sets of houseparents shared one bedroom according to their rotating schedule. The houseparent's bedroom was conveniently located between the other two bedrooms. The remaining two bedrooms were shared by a maximum of six children. The children's bedrooms had a range of beds: there was a standard twin bed in each room, one roll-away twin in storage, one infant crib on rollers, two convertible crib beds (sides removable), and one standard crib. Generally this selection was adequate for the varying groups of children. However, there were a few times when the Crisis Nursery population consisted of four children, five years and older, and another standard bed would have been more comfortable and appropriate. One chest of drawers is each bedroom was sufficient. Only one of the two children's bedrooms had a closet, which was inconvenient. Both rooms had two windows, making the rooms light and airy. Optimally, a six child Crisis Nursery should have at least four bedrooms. There was usually at least one child with a runny nose, diarrhea, or some other childhood disease, and having separate bedrooms might have lessened exposure to contagious diseases. Also, bed and naptimes might not have been such a problem.

Having one bathroom seldom presented any problems. Schedules were easily adjusted to meet various needs. There was one bolted cabinet in the bathroom that contained cleansers, paper products, etc. The bolt was out of the reach of little ones. The houseparents added an outside lock to the bathroom, which was also out of the reach of little ones. Its purpose was to discourage playing with the toilet, faucets, etc.

The kitchen was of fair size. Besides the usual cabintry and appliances, it had enough space for a table with six or more chairs and two highchairs. The Crisis Nursery had three highchairs. With several toddlers in the home, their trays would be removed and placed at the table.

The living room was furnished with a sofa, rocker and comfortable chair. Also, lamps, tables, television and stereo were in the living room. A tall metal cabinet was used to hold medicines, puzzles, paints and games. The cabinet had a lock so it was not readily accessible to the children. As a general rule, the children asked if they wanted something from the cabinet. Possibly the greatest need for a Crisis Nursery living room is having comfortable furniture, which is appealing to the eye, as well as practical in terms of wear and cleaning.

The playroom was adjacent to the living room and was the children's primary play space. However, they freely moved about the nursery unless they might interfere with someone else's work or play. There were several child size desks, tables, and chairs; bookshelves for toys and books; building blocks, a play kitchen; stuffed animals, large toy boxes, and other toys, from which the children were allowed to choose. The playroom had three windows and was very sunny. It was carpeted to reduce the noise level and to cushion falls, but judging from the carpet's condition, vinyl flooring would have been more practical. Play Dough and painting were favorite activities with the children, but they had to be limited to the kitchen table because of the carpeting in the playroom. Most likely a thickly cushioned vinyl flooring would provide the advantages of cushioning a child's fall and reducing the noise level as well as being practical for play and clean-up purposes.

The Crisis Nursery was equipped with a myriad of toys. Some had been donated, others were carefully chosen by the houseparents. Punching bags were popular among children five years and older. They provided a socially acceptable means to act out hostilities and frustrations. Theoretically, these punching bags could serve a cathartic purpose. They were made of an inflatable plastic, weighted at the bottom.

Stuffed animals were another popular item. The Crisis Nursery had a wide variety and the houseparents would subtly encourage a child to attach to one if they showed an interest. These stuffed animals also occasionally became acceptable objects of projection, especially when a child first arrived at the Crisis Nursery. When the children left the nursery they kept the stuffed animals.

A play kitchen provided some impetus for imaginative houseplay. It was equipped with dishes, pots, and pans, etc. Sometimes children would become very elaborate in their imaginative games and create a restaurant or store, to which others were invited.

Pull toys and building blocks attracted toddlers and aided in their development of motor skills. Trucks and cars were enjoyed by a wide variety of ages, both in the playroom and in the sandbox.

Two large toy containers were in the shapes of a train and an elephant. The children used them as objects within which to hide themselves. Another example of private space was the covered backyard sandbox, which had two spaces built into the back of it that were walled in on three sides. The nursery needed more such areas.

Being an older house, the Crisis Nursery had several nooks and crannies. One was occasionally used as a time-out place. It was a small entry area, approximately 4 ft. x 4 ft. Its advantage was that it could be completely closed off. When a particular child was misbehaving, and a time-out in a corner or his/her room was not sufficient control, he/she would be placed in this "time-out" space for two or three minutes and told that he/she could come out when he/she was ready to behave. Perhaps a more efficient facility might include a better equipped time-out space, especially for the more violent or aggressive child. Improvements for a time-out space would include: a slightly larger space, with protected windows and no objects with which a child potentially could hurt him/herself. The Crisis Nursery had several children who might have benefitted from such a place, learning that certain behavior was not acceptable and they would have to control it before they came out.

Another reality of having an older home was a high incidence of maintenance problems, The houseparents felt that they spent an inordinate amount of time with various problems of the house. Some of the problems could be expected with any home, i.e., replacing garbage disposals, faucets, handles, repairing the washer or dryer. But many other problems stemmed from the fact that this was an older home and had the usual structural and plumbing problems. However, it was a homelike environment for its occupants unlike most institutions. Therefore, it was easier for children to adapt to placement.

Staff

Initially the Crisis Nursery staff consisted of one full-time couple and two weekend relief couples. The director of the Family Center acted in a supervisory capacity. The Family Center nurse made daily visits and was available for any questions the houseparents might have.

In the first months of work, the houseparents concentrated on preparation for the Crisis Nursery's opening and began a training program including:

1. A three day overview of child abuse at the National Center for the Prevention and Treatment of Child Abuse and Neglect.
2. Three sessions with a nutritionist from local public health agency, Tri-County Health.
3. Consultation with a "Homebound" coordinator from the JFK Child Development Center on infant stimulation and information.
4. Consultation with the Family Center nurse concerning normal child growth and development, how to recognize symptoms of illnesses, and basic first aid instructions.
5. Consultation with a speech therapist from the University of Denver Speech and Audiology Department on speech and language development and remediation.
6. Consultation with perceptual-communicative teachers on addressing behavior problems in children with perceptual limitations.
7. Consultation with behavioral therapists on how to deal with general and specific behavior problems.
8. Various in-services with the Family Center staff.
9. Three Colorado Child Care Association Conferences dealing with control issues; behavior disorders; and transitions from institutions to families.
10. A community college class on day care.

Some of these training programs continued after the Crisis Nursery opened in February, 1975. The houseparents believed most of these programs were beneficial and basic to each child, but did not deal with the specific needs of the abused child. Because of the uniqueness of the houseparents' position, there were no courses of instruction to specifically address their needs. The concept of a treatment program in a home setting to care for and treat the abused or potentially abused child was experimental and there was no available information on what the specifications of a position should be. The scope of houseparent training was restricted by the limited research and literature concerning the treatment of abused children. The houseparents tried to remain as eclectic as possible and learned from the children in the Crisis Nursery what they required. The child's behavior was usually a clear enough statement as to what he/she needed. The houseparents attempted in a variety of ways to meet those needs. They found through experimentation what was effective and what was not. No matter what other specifics the houseparents could provide to meet the needs of a particular child, a consistent and nurturing environment was the core of the program.

CRISIS NURSERY HOUSEPARENT JOB DESCRIPTION

JOB TITLE: Houseparents - couple

JOB SUMMARY: Provide parenting and custodial care in a family crisis center for abused children.

REPORTS TO: Director of the Family Learning Center

DUTIES:

1. Provide for psycho-social and developmental needs of children removed from their own homes, that is, parenting roles, infant stimulation, helping children deal with separation from parents and siblings, toilet-training, etc.
2. Provide supervision to as many as six children at a time.
3. Provide regularly scheduled feeding.
4. Be available on a crisis basis to receive newly-admitted children at any hour.
5. Participate in regularly scheduled weekly Family Center staff meetings.

6. Maintain records and reports on children placed at the Family Learning Center.

7. Plan, shop for, and prepare three meals/day for children placed at Family Learning Center.

8. Manage funds allocated for food and household items.

JOB SPECIFICATIONS:

A. Education - a high school diploma or commensurate skills.
B. Experience - A minimum of one year working with infants or pre-school age children. This may be personal or professional experience.
C. Personal - Ability to work with professional staff in a multidisciplinary team approach.
D. Salary - $9,000/yr. for two persons, plus room and board. Additional 14 percent fringe benefits.

The houseparents were responsible for completing behavioral forms on the children at regular intervals. These forms, as well as demographic data, were used in the research of the Crisis Nursery and its effectiveness. The houseparents made arrangements for the children's other evaluations, that is, medical, psychological, and speech and hearing. The houseparents frequently provided transportation to and from these evaluations, but were not involved in the actual evaluation process.

The precedents for a foster care type of facility had consisted of one set of primary caretakers. The Crisis Nursery intended to follow this example, while providing relief with a weekend couple. It was thought that this system would be advantageous financially and provide consistency to the children placed at the Crisis Nursery. There were several problems evident in the first few months of operation. The Family Center had difficulty in finding a consistent relief couple. Usually, a weekend couple worked elsewhere weekdays and working seven days a week was too exhausting. The position of a houseparent was a difficult and tiring one. The expectations were too great and salary was too low for a weekend couple. Because of this, one couple seldom lasted long. As a result of never knowing if there would be relief help on weekends, the full-time houseparents became quite anxious. There was not a consistent system upon which they could rely.

The children had difficulty relating to this everchanging weekend staff. The houseparents were aware that consistency was of upmost importance to these children and they were not receiving this under that staff system. Several times, children were moved to foster homes over a weekend, if replacement staff could not be found. They were angry after being shuttled about. Houseparents returned to the additional task of working through that anger.

The strain of working twenty-fours a day, five days a week was a considerable one for the houseparents. A two day relief period was not enough time for them to be rejuvenated. The regular houseparents would often feel guilty about leaving the children on weekends. The weekend people were not trained and essentially became baby-sitters. Upon returning, the full-time couple often found the Crisis Nursery in disarray and had be devote considerable time and energy toward calming things down and their energy level lessened. They felt their effectiveness with the children suffered as a result of this combination of too much work, too little time off and the resulting anxieties. The Family Center staff believed that the Crisis Nursery could not be a well functioning child care and treatment center offering consistently high quality service until the staffing problems were settled. One viable solution to this problem was to employ a second set of full-time houseparents working a four day sequence.

By having a second set of full-time houseparents, many problems were alleviated. The rewards of being full-time were sufficient to maintain the new couple and they did not need another income. Their four days off could be used for rest and relaxation. The responsibilities of houseparents were shared equally. Such chores as shopping and cleaning were divided, thus lifting a burden from the original houseparents. Also, responsibilities in caring for the children, dealing with parents and communicating with workers were shared. No longer was the second houseparent couple merely babysitters. They shared in all of the responsibilities and the decisions that needed to be made. The four day on/off schedule proved to be most effective. The new schedule proved to raise the quality of work. The houseparents could devote their time and energies to the children, no longer worrying about staffing and having a reasonable workload.

It was also much easier and healthier for the children to relate to only two consistent, full-time couples. The houseparents shared the same philosophy as opposed to various weekend couples with differing approaches to child management. Another major benefit was the assurance of trained and competent houseparents at all times who could deal responsibly with crises and placements.

Both the project director and supervisor found their work simplified. They no longer had to divert energy from other duties to securing weekend houseparents.

There was another advantage which was not anticipated by the houseparents. It was found that the houseparents became less possessive of the children in the Crisis Nursery. Knowing that there were two different sets of caretakers, who were equal in their time investment, made a strong emotional attachment to a child more improbable. The houseparents knew that they alone were not the primary caretakers and, therefore, were sharing the responsibility for the children. Whereas, when one set of houseparents was primary, as on a five-two schedule, they were more likely to attach strongly to a child because of their higher level of investment.

Social workers from the county protective service department and other professionals from schools, hospitals, mental health clinics, etc., also developed greater confidence in the stabilized Crisis Nursery, as evidenced by a greater willingness to use the program.

The houseparents position at the Crisis Nursery had several unique qualities that made it different and complex. The position demanded a great deal of emotional and personal involvement and led the houseparents to feel that they were often involved in more than a traditional job. Houseparents were required to provide children with physical closeness as well as providing emotional warmth. The intagibles, such as warmth, kindness, positive regard, etc., provided by the houseparents required considerable energy and could not be readily evaluated. A requisite of the houseparent position was the ability to meet children's emotional needs. but assessing the houseparents' ability to do this was not easy through interviewing. References were found to be the best material for evaluating a potential houseparent's capabilities for providing emotional nurturance. This expectation dictated a certain level of emotional attachment to children and frequently resulted in difficult terminations for the houseparents. It is important to note that this emotional involvement created difficulties, not only with regard to terminating with children, but also in the houseparents' ability to separate from their work and see their job as simply a job.

The situation at the Crisis Nursery was such that reliable relief help was not readily available. The use of time off for illnesses, compensatory time or annual leave was not easily arranged. Often the houseparents experienced feelings of guilt when they used such time off and felt the relief care was insufficient or incompetent. Feelings that the children suffered in such situations were central to the problem. Annual leave time required that both sets of houseparents make adjustments in their schedules and this presented difficulties. In summary, the basic design of the houseparent job in the Crisis Nursery required emotional investments by the houseparents which created a much greater emotional investment in the work than is found in many jobs. The houseparents discovered that it was difficult to separate their personal lives from their job. Recommendations were arrived at the completion of the project to attempt to alleviate this situation. (See Section 8).

The houseparent job was also found to be unusual in the complexity of its requirements. The houseparents were asked to perform the sophisticated tasks of providing treatment for children, performing as role model parents, evaluating parent-child interaction, providing input into case plans, etc., but they were also required to change dirty diapers, scrub floors, do laundry, cook and wash dishes. This diversity of tasks required a person with a certain level of professionalism, but also one willing to perform the more menial tasks involved in the care of children and the maintenance of a home. The importance of maintenance duties should not be underestimated. A great deal of the houseparents' time and energy was invested in maintenance tasks. It is equally important to point out that the non-maintenance tasks of emotional nurturance, modeling, evaluation, and providing inputs into case plans was often equally demanding, but inherently more rewarding. A person capable of providing good emotional nurturance but unwilling or incapable of doing household work is equally unacceptable as a houseparent as is a person who can provide maintenance without nurturance.

This dual role aspect of the houseparent job also created some feelings of resentment and anger. The houseparents found it difficult to take responsibility in family treatment and also to shovel snow or cut the lawn. It was also difficult for the houseparent to accept, as inherent in their position, a certain level of impotence in affecting case plans and children's destinies. Recommendations for alleviating some aspects of these problems are suggested in Section 10, but it may be necessary for supervisors to deal with some degree of resentment and anger involved in this paraprofessional position.

The houseparents also discovered that working with one's spouse in a crisis nursery setting can create strains and conflicts. The crisis nursery situation was demanding and often created stress and tension. Houseparents were required to be ready to deal with crisis situations at any moment, 24 hours a day for four days. The situation at the Crisis Nursery was such that houseparents had to depend on their spouses for nearly all gratification of needs for adult companionship. Much of the time this was not a problem, but during periods of stress and fatigue, the situation created strains in relationships.

A second aspect of this dynamic was the fact that houseparents were involved in a work situation that required maintaining not only a personal relationship with their spouse, but also a professional relationship. It was found to be somewhat difficult to adequately separate these two roles, as co-workers, spouses experienced greater than average conflict over disagreements.

This problem was compounded by a third dynamic, that being the maintenance of personal identity in a job requiring a married couple. The houseparents discovered that people outside of and within their agency viewed them as a unit rather than two separate individuals with the potential of holding opposing views. There appeared to be an unverbalized expectation that each set of houseparents would act as a single unit. These expectations coupled with the added dynamic of emotional involvement made disagreements between spouses more pronounced and difficult.

A final aspect of the houseparent position, which had a detrimental effect on marital relationships, was created by two factors. First, the time the houseparent couples spent together at the Crisis Nursery was usually stressful and demanding. Secondly, the time available away from the nursery for engaging in stressful and pleasurable activities was also the only time houseparents could spend alone to pursue individual interests and relationships. This situation necessitated a choice between spending pleasurable time together, thus limiting the time available for individual activities, or sacrificing pleasurable time together resulting in the houseparent couple spending the majority of their time together in a demanding situation. Neither of these choices provided time to meet adequately the individual houseparent's needs for time alone and time with his/her spouse in a non-demanding situation.

There were many rewards to working with one's spouse and these will be discussed later. Recommendations concerning the marital strain dynamic of houseparenting are discussed in the following text.

The need for houseparents to be flexible has already been mentioned. A certain degree of flexibility was found to be an essential quality in houseparents. A crisis placement could and did come at all hours of the day and night. Children's special needs required nighttime feedings or other special schedule adjustments. A houseparent could not count on meeting his-her own needs for rest and relaxation during a specific time each day. This aspect of the job necessitated a willingness to change schedules and plans and delay the gratification of one's own needs. The final schedule of four days on and off also necessitated flexibility due to the fact that one's time off was constantly changing.

However, that this level of flexibility should not lead to a lack of structure or inconsistency in job performance. As has been previously stated, structure and consistency are of great importance, so a blend of the abilities to be flexible as well as structured whenever possible were found to be optimal for houseparents.

A final problem encountered by houseparents was an aspect common to many paraprofessional positions. The houseparents were in a position to be the closest observers of the children and their interactions with others. In many cases, they were capable of formulating competent evaluations of children's needs and their relationship to peers, siblings, and parents. In some cases, this information was solicited and used appropriately. There were, however, instances of family workers who wished to receive little or no advice or information from houseparents. This situation was often frustrating for houseparents as well as a source of resentment and anger. The houseparents felt more like caretakers than contributors to the case. The Family Center houseparents were in a unique position due to their status as a part of a "special project" and some resentments from the sponsoring agency likely resulted from this situation. Houseparents needed to be aware that expectations of what their role was to be varied widely. This lack of consistent role definition produced frustration and anger which could be anticipated and dealt with.

Although the houseparent job at the Family Center's Crisis Nursery was demanding and strenuous, it also provided many rewards. The financial reimbursement was minimal and fringe benefits were adequate. Obviously these were not the primary source of the houseparents' gratification. The rewards of the job lay in the experiences of working with children, parents, staff and the community.

The opportunity to engage in a helping relationship with children provided a large measure of the rewards of houseparenting. Providing children with the opportunity to experience living in an affirmative environment held its own intrinsic rewards.

The children shared their needs, genuineness, and affection with the houseparents and the opportunity was provided to help the children meet their needs. This sharing and helping process provided the houseparents with needed feelings of worth and competence. The houseparents had the opportunity to become significant people in the lives of children and develop relationships of trust and affection. The children demanded a great deal of energy and attention, but they returned the gratifying intangible rewards of affection and trust, and provided the tremendously rewarding experience of watching them learn and grow.

Work in the Crisis Nursery also provided many learning experiences. The major responsibility of implementing behavior control and nurturing programs was given to the houseparents. This provided the freedom to implement new and innovative concepts and witness the resulting successes and failures.

Houseparents learned a great deal about children through their work. The work provided experience in parenting children of many different ages and personalities. Houseparents acquired a good knowledge base regarding child development, personality, and medical issues. The houseparents also became well versed in the literature and understanding of the dynamics of child abuse.

The Crisis Nursery also provided an environment in which one learned about oneself. The houseparents were forced to face crisis situations and through the experience of handling crises and stress, houseparents gained insights into their own capabilities and personalities. This same environment provided couples with the opportunity to learn and grow with each other and to discover complementary roles and functions.

Working in a social service system also provided valuable experience and insight into administrative and organizational issues. Relationships with a supervisor and other staff were found to be valuable and educational.

Although instances of natural parents giving houseparents social rewards for their work were rare, it did occasionally happen. Parents who implemented new ways of parenting their children and showed growth in using non-abusive ways of relating to their children, indirectly rewarded houseparents by their progress. In some cases, parents provided direct rewards by commenting on their child's growth and by thanking the houseparents for their efforts.

Family workers also gave the houseparents reinforcement by complementing progress and growth in a child or family relationship. Family workers also rewarded houseparents by soliciting and making use of their insights and information.

The houseparents position carried inherent rewards in the outside community. The community was appreciative of the menial aspects of the position but especially supportive of the social value of the work the houseparents did with the children. It was not rewarding to be considered "saintly do gooders" but it was rewarding to speak at community functions and have the work seen as valuable and worthwhile.

Nurse Involvement in the Crisis Nursery

The two primary responsibilities of the nurse were to provide health care to the children placed in the nursery and consultations to the houseparents.

As soon as a child was placed in the nursery, the nurse made an assessment of the site, color and degree of injury and scheduled a complete physical examination for the child within seven days. The physical examination was completed by the county public health department, a private physician or the Family Center pediatric nurse practitioner, and included:

1.) Social and Medical history of the Child
2.) Physical Examination
3.) Visual Acuity Test
4.) Development Screening Test

The nurse made daily visits to the nursery to check on the children's health, to treat any bruises, colds or communicable diseases, and to take throat cultures when necessary.

Consultation was provided for the houseparents regarding infant stimulation, ideas on child management techniques and proper diet, and special handling of handicapped children.

Students and Volunteers

A variety of ways were discovered for using student interns in the context of the Family Center Crisis Nursery. Two or three students per semester from the Career Enrichment Program of the local high school selected the Family Center for field placement and received high school credit for their work. These students were required to spend a specific number of hours per week in the nursery. These hours were supplemented by time in formal classes on areas related to child development, and required readings from bibliographies compiled by their teachers and Family Center staff. Rather than working with individual children, the students worked with small groups of children, addressing common developmental tasks. Areas with which students dealt included language development, peer relationships, and gross motor development. Some of this work was carried out in the nursery, but students frequently planned expeditions into the community (libraries, swimming pools, parks, restaurants, theaters, and museums).

College social work interns worked in the nursery with individual children and their families. A model of one such relationship involved an extremely aggressive, provocative, and hyperactive boy and his very depressed mother. The college intern began working with the child in the Crisis Nursery to establish a relationship between the boy and herself. The behavior program that she implemented produced changes in his ability to relate to people. When the child returned home, the intern saw him and his mother in their home several times a week. Behavioral programs started in the nursery were continued and taught to the mother. The mother improved in management skills and became less depressed. The functioning of the family unit as judged by the family social worker significantly improved because of the intervention.

One problem that arose with this program was the amount of houseparents' time it consumed. At the beginning of each semester, a houseparent made a presentation to the career enrichment classes and talked with prospective interns. At least one hour per week was required to meet with the interns to discuss behavioral issues that might have arisen, to plan for successive sessions, to answer questions, and to recommend reading materials. Though demanding in terms of houseparent time, the student placements were worthwhile in that they reduced the isolation of children in the nursery and enlarged treatment alternatives; gave houseparents time away from the children for meetings, paper work or housekeeping chores; and provided the students with a valuable experience of working with the emotional and developmental problems of children.

Another problem was that the length of student involvement was necessarily limited by the end of their school term. Other issues that arise when dealing with volunteers in a crisis nursery setting include their availability on a regular schedule, confidentiality, and consistency throughout the treatment program. Volunteers working directly with crisis nursery children need to be able to set and enforce appropriate limits for the children. Although on some occasions volunteers were used in the Family Center Crisis Nursery to relieve emergent situations, this arrangement was not successful in fostering continuing positive direct relationships.

Various individuals and community groups did make material contributions to the nursery that were helpful. In addition to the donations made at the open house, high school art classes contributed paintings; a community worker painted a mural; a teachers' group made stuffed animals, hand puppets, and bought a DUSO kit (an affective education tool); a girl scout troop provided annual Christmas trees and dinners; etc. It was the judgment of the houseparents that these kinds of indirect and short-term relationships were probably the better use of volunteers in the Crisis Nursery than the contribution of the student interns.

Supervision of Crisis Nursery

All of the issues discussed about supervision, whether relating to intake or to ongoing cases, have relevence in relation to supervising the Crisis Nusery houseparents. The atmosphere has to be one of trust and respect as well as of empathy and encouraging growth. There are some special issues in supervising houseparents which are unique to that situation. These include issues involved in supervising paraprofessionals and the special needs of supervisors who work 24 hours a day.

Issues often arise between social workers and paraprofessionals feeling intimidated by professionals, who sometimes wish to be seen as omniscient and omnipotent. If the houseparents were treated with respect, this issue was kept at a minimum. Keeping the houseparents involved as team members with equal input into case decisions was important. When input from houseparents was not requested by the worker, or was not used in making decisions, problems arose. It was the role of the supervisor to try to open up communications between all involved. This process of facilitating communications was fostered by the supervisor spending time with social workers and their supervisors to help educate them about the work houseparents were doing with the children and their parents.

Working with children on a 24 hour a day basis, when they are often acting out, is difficult. Although the houseparents sometimes needed direct supervision at times they just needed to talk with an interested, professionally stimulating adult. The houseparents utilized the supervision for helping design appropriate treatment programs for specific children, as well as designing appropriate means of discipline for each child.

One of the most difficult areas was with the houseparents transference in relation to the children. When children came into the nursery with developmental lags and behavior problems and the houseparents were able to effect change, it was often difficult for them not to become overprotective of the children when the children were interacting with their natural parents. These feelings needed to be resolved. This helped the houseparents accept the fact that their job was not just to provide adequate care and treatment for the children, but to help them get reestablished in their natural family.

Decisions as to what children were accepted into the nursery were sometimes made by the houseparents. They knew not only the general guidelines for placement but also what kind of children they could handle. If the Crisis Nursery already held special needs children, then the houseparents could turn down a referral, even if the nursery had the space. This often became a bone of contention for the department of social services, but refusal was sometimes necessary to provide quality care. It was also necessary that the supervisor support this concept. However, there were times when it became necessary for the supervisor to override a decision by the houseparents in an effort to find a balance between the nursery's needs and the systems needs. When this was done, it was of paramount importance that an explanation was given to and understood by the houseparents.

The two different couples had distinct styles and personalities. It was very important that there be a continuity of service to the children, so these differences needed to be understood. Such differences were best resolved if the couples communicated any differences between themselves, instead of having the supervisor mediate their difficulties. At times, however, the supervisor was needed to help facilitate communications.

The houseparents needed to feel supported and that at any point there was staff available to them. Encouraging the houseparents growth, and letting them know they are not just caretakers but rather a part of the treatment team will ensure the best possible atmosphere for all concerned.

Outcomes

The Crisis Nursery program was designed to provide crisis care, evaluations, and treatment for abused children in Adams County. In achieving this goal the staff and community learned the importance of having such a facility available for parents and children.

Over the twenty six months the Crisis Nursery was operating, the program provided care to 121 children (Refer to Table 1). Of the 109 children placed at the Crisis Nursery, ninety-one percent met the criteria of being abused or in a potentially abusive situation. The average length of stay at the nursery was twenty-three days, indicating that treatment was short term. The average length of stay, however, may not be totally representative of the actual needs exhibited by the Crisis Nursery clientele. The twenty-three day figure should be evaluated in conjunction with the facts that: 38 percent of the children went to foster care after a Crisis Nursery placement; a small number of cases required an extension of the 60 day limit on placement; and the average length of placement figure includes several overnight and very short placements. It is believed that the Crisis Nursery was successful in providing short term care for abused and potentially abused children between the ages of birth through twelve years.

Table 1

Family Center
Crisis Nursery Statistics
(February 1975 - April 1977)

	1975 (10 Months)	1976 (12 Months)	1977 (4 Months)	Total
Total Number of Children Placed	45	64	12	121
Average Age of Child	3.6 Years	4 Years	4 Years	3.8 Years
Sex				
Male	32 (71%)	32 (50%)	7 (58%)	71 (59%)
Female	13 (29%)	32 (50%)	5 (42%)	50 (41%)
Ethnicity				
White	41 (92%)	54 (84%)	9 (75%)	104 (86%)
Black	0	2 (3%)	2 (17%)	4 (3%)
Chicano	2 (4%)	8 (13%)	1 (8%)	11 (9%)
Other	2 (4%)	0	0	2 (2%)
Severity Of Abuse				
Severe	3 (7%)	3 (5%)	1 (8%)	7 (6%)
Moderate	5 (11%)	9 (14%)	3 (25%)	17 (14%)
Mild	4 (9%)	12 (19%)	1 (8%)	17 (14%)
Failure To Thrive	1 (2%)	1 (1%)	0	2 (2%)
Sexual	0	2 (3%)	0	2 (2%)
Potential	26 (58%)	32 (50%)	6 (50%)	64 (53%)
Child Place For Reasons Other Than Abuse	6 (13%)	5 (8%)	1 (8%)	12 (9%)

Table 1 (cont'd)

Family Center
Crisis Nursery Statistics
(February 1975 - April 1977)

	1975 (10 Months)	1976 (12 Months)	1977 (4 Months)	Total
Type of Placement				
Voluntary	29 (64%)	42 (66%)	7 (55%)	78 (64%)
Court Ordered/ Police Hold	16 (36%)	22 (34%)	5 (45%)	43 (36%)
Average Length of Placement	22 Days	25 Days	21 Days	23 Days

Post Nursery Placement

	1975 (10 Months)	1976 (12 Months)	1977 (4 Months)	Total
Own Home	18 (40%)	32 (50%)	6 (50%)	56 (49%)
Foster Care	23 (51%)	22 (34%)	5 (42%)	50 (38%)
Other (Residential treatment or relatives)	4 (9%)	10 (16%)	1 (8%)	15 (12%)

As is indicated in the recommendations, the houseparents believed that they were least effective in meeting the needs of the older children placed at the nursery, specifically the 11 and 12 year olds. The average age of children placed at the Crisis Nursery was 3.8 years. The houseparents believe that the programs at the nursery were best suited for toddlers and younger children.

Sixty-four percent of placements at the Crisis Nursery were made voluntarily by parents. Fifty-three percent of children placed came from potentially abusive situations. These high percentages indicated that the Crisis Nursery was successful in providing a facility where parents who felt the potential to abuse their child could voluntarily place their child for short term care.

The Crisis Nursery was used successfully as a facility for the care of children while parents were assessed to determine the "risks" to the child. Forty-nine percent of the placed children returned to their own homes, thirty-eight percent went to a foster home, and thirteen percent were placed in residential care or with a relative. (These percentages do not include foster children placed while foster parents vacationed.) These figures indicate that in 51% of the cases it was believed that children would be "at risk" if returned home.

The houseparents believed they were successful in providing valuable input into evaluations of parent/child interactions and the parent's parenting skills. It was not believed, however, that this input was used as effectively as was possible.

The houseparents effectiveness in providing modeling of appropriate behavior for natural parents was limited by the parent's willingness to become involved in this process. It was believed that, when parents actively involved themselves in the Crisis Nursery, the houseparents could achieve a substantial level of success in modeling appropriate parenting skills.

The use of tests and evaluations described in the following text was highly successful in determining children's needs. The testing incorporated scales and subtests that were helpful in identifying specific areas of needs and strengths.

The cost effectiveness of the Crisis Nursery was demonstrated as illustrated in the following Table 2. A comparison of cost per child for sixty days of Crisis Nursery care and eighteen months of foster placement (the average length of foster placement in Adams County) showed a cost savings of at least $2,797 per child per year. A comparison of sixty days of Crisis Nursery care and twelve months of residential care (the average length of residential care in Adams County) showed a saving of at least $8,972 per child per year. An explanation of how these figures were developed can be found in Table 2. Clearly, the Crisis Nursery provided treatment for families at a much lower cost than foster or residential care.

Testing and Evaluations

Each child placed at the Crisis Nursery was evaluated developmentally, psychologically, and medically. Within the first week of placement at the nursery, children received a complete physical examination administered by a local doctor or the Family Center's nurse.

Developmental and psychological tests were administered by two major sources. The determination to test children placed at the Crisis Nursery was based on the hypothoses that abused children would exhibit developmental lags in areas of language, speech, fine and gross motor activities, mental capacities, and emotional growth. It was hoped that the battery of test administered to children while in placement at the Crisis Nursery would shed light on the degree of developmental variance from the norm, and facilitate recommendations for treatment and alleviation of developmental handicaps.

TABLE 2

COMPARRISON OF COSTS

CRISIS NURSERY CARE - FOSTER CARE - RESIDENTIAL CARE

(All costs based on a monthly, per child expenditure)

CRISIS NURSERY CARE MONTHLY COST PER CHILD		FOSTER CARE MONTHLY COST PER CHILD		RESIDENTIAL CARE MONTHLY COST PER CHILD	
$120	Case Maintenance	$120.00	Case Maintenance	$120	Case Maintenance
$270	Houseparent Salaries	$146.50	Average Monthly Fee Paid Foster Parents	$720	Average Monthly Fee Per Child
$ 14	Supervision Provided to Houseparent Staff	$ 6.00	Foster Home Recruitement		
$ 71	Food				
$ 38	Rent				
$ 13	Utilities				
$ 11	Insurance				
$ 17	Facility				
$554	TOTAL MONTHLY COST PER CHILD	$272.50	TOTAL MONTHLY COST PER CHILD	$840	TOTAL MONTHLY COST PER CHILD
$554 x 2 months = $1,108		$272.50 x 18 months = $4,905		$840 x 12 months = 10,080	
(2 months is maximum placement)		(Average length of foster placement in Adams County is 18 months)		(Average length of residential care in Adams County is 12 months)	

*Case Maintenance includes salary of social worker involved, fringes, overhead, travel, administration, etc.

Infants, two months to thirty months, were given the Bayley Scale of Infant Development by a psychiatrist from the University of Colorado Medical Center. He also evaluated parent-child attachment and interaction through the application of his own paradigm. Children 2½ to 8½ years old were given the McCarthy Scales of Children's Abilities by a doctoral candidate in clinical psychology at the University of Colorado. The Wechsler Intelligence Scale for Children (WISC) was administered to children over 8½ by the same doctoral candidate. On occasion, the Denver Developmental Screening Test (DDST) was administered by the houseparents or the Family Center's nurse.

These particular tests were chosen because they were felt to be the most adequately standarized developmental tests. It was felt that these tests were particularly good for diagnostic purposes due to their breakdown into subtests. The subtest scores indicated particular areas of need and strength.

The Bayley can be used to measure mental development as well as psychomotor development. In this setting, the tester obtained only mental scale scores. The items on the mental scale measure such things as response to visual and auditory stimuli, manipulation and play with objects, socialization and simple problem solving, naming objects, etc. The psychiatrist also evaluated parent-child attachment and interaction for infants 0-30 months. This was done by the use of a research paradigm designed by him. He videotaped children in situations where they separated and interacted with a parent (usually the mother, but in some cases a houseparent played the mother's role) and compared this to the children's interactions with and separations from a stranger (the psychiatrist). This pradigm proved extremely helpful in evaluating the quality and nature of parent-child relationships.

The McCarthy Scales of Children's Abilities measured the child on six scales: Verbal, Perceptual Performance, Quantitative, General Cognitive, Memory and Motor. The combination of Verbal, Perceptual and Quantitative scores were used to compute a General Cognitive Index.

The WISC is an intelligence test used to measure verbal and performance abilities. Verbal and performance scores were combined for the full scale score which would be considered the child's I.Q. The verbal test included items such as Information, Comprehension, Arithmetic, Similarities, Picture Arrangement, Block Design, Object Assembly, Coding and Mazes.

The Denver Developmental Screening Test was used to identify specific areas that should be further evaluated. The DDST evaluates four areas of development: Personal-Social, Fine Motor-Adaptive, Language, and Gross Motor. It is not to be used as a comprehensive test, but as a screening instrument for further testing. It is appropriate for children from birth to six years old.

The University of Denver Speech and Audiology Department provided evaluations for the children placed in the Crisis Nursery. This arrangement provided for student training and thorough assessments for the nursery children. Initially, this testing was completed at the nursery due to the program's inability to transport children to the University. However, the Family Center received funding for a community service aide through the CETA program. This aide then transported the children for evaluations and speech therapy.

This testing resulted in assessments of the children's hearing acuity, auditory descrimination, auditory sound closure, auditory reception, auditory memory, and visual reception. The children's responses tested the following:

Retrival - How well can he/she find the word he/she needs;
Syntax - How does he/she order words;
Semantics - Does his/her speech have appropriate meaning?

Additionally, a language sample was analyzed according to Lee, Berry, and Templin and assessments were made of the oral peripheral structure.

Parts of the following specific tests were used age appropriately:

1. Audiological Screening
2. Peabody
3. ITPA
4. Templin Darley Test of Articulation
5. Aten-Denver Test of Auditory Sequencing
6. Denver Developmental
7. Spencer Memory for Sentences
8. Detroit Subtests (Detroit Test of Learning Aptitude)
9. Language Sample Analysis
10. Oral Peripheral Exam
11. Goodnough Draw-A-Man

Copies of the results of all testing and evaluations were made available to the family worker, houseparents, and Family Center researcher. This information was found to be helpful for immediate treatment as well as long term planning.

For the purpose of researching the effectiveness of treatment in the Crisis Nursery and to examine the nature of the abused, neglected, and potentially abused child, the houseparents kept records of child behavior and attitudes by use of four forms. These forms were developed by Family Center staff under the supervision of the center's researcher and research consultants. The forms were pretested in the Crisis Nursery and revised.

The forms included a checklist of the child's behavior, a Rating of the Child's Interaction with Parent/Foster Parents, Child's Adjective Checklist, and a Semantic Differential Form. Copies of these forms may be found in Appendix XI.

Houseparents filled out the first set of forms within 24 hours of placement, again after one week, two weeks, one month, two months, and finally at termination. The results of this research are discussed in the research section of the text.

Records of demographic data which included the child's date of birth, ethnicity, and index of abuse were kept for each child. Demographic statistics for the Crisis Nursery children are displayed in Table 1.

Recommendations

After twenty six months of operation the Family Center Project has identified many recommendations for others interested in developing similar programs. These recommendations are suggestions to be added to the content and processes presented in the previous material.

- The staffing pattern of having two couples working twenty-four hours per day for four days is a better pattern than five and two days with relief couples for the weekend. The eight hour shifts for staffing a nursery is not recommended primarily because of the many adults children would have to adapt to in their Crisis Nursery placement.
- The project's houseparents have recommended a salary of minimum wage per hour for sixteen hours per day. This staff did not receive that amount, but did receive benefits of food, shelter, and some recreational expenses for their work days.
- Houseparent staff received fringe benefits equal to the project staff in relation to retirement, insurance, and sick leave. However, they did receive twenty four-hours for each ten hours of annual leave that the rest of the staff received. Thus, the houseparents' annual leave time should be changed to accomodate a more equitable system of allotting leave time accrued. One suggestion would be to close the nursery for one month to allow for the staff to have a much needed vacation.
- Trained relief staff to be used as babysitters for the children when houseparents are ill is highly recommended. These same individuals could be used when houseparents need to attend team meetings, inservice training meetings, or during the change over time when houseparents are discussing the children.
- Initial and ongoing training in the areas of nutrition, child growth, and development; and behavior management would be very beneficial to the Crisis Nursery staff.

- It is recommended that a supervisor be available on regular and intermittent times for guidance and support to the houseparents. A minimum of fifteen hours per week would be an adequate amount of time.

- It is recommended that the age limit of community based crisis nurseries for abused children would range from birth through age 10. The Family Center's range was birth through age 12 and thus, the pre-teen child was often resentful of being in a "nursery" and of being in a program geared to younger children.

- On those cases where staffings on the child placed occurred, the program was better able to meet that child and family's needs, Thus, it is highly recommended that staffings should include a discussion of the case plan, expectations of workers and houseparents, and parental visitation.

- The Crisis Nursery program should write in its criteria the right to limit the population of the nursery at times when there is an especially difficult child in residence.

- A nursery program is usually guided by licensing laws of its state of residence and these regulations dictate the number of days a child can be placed in such a facility. Thus, this Crisis Nursery had a maximum of sixty days. These regulations need to be adhered to, but there is benefit in having an agreed upon flexibility for particular children. Prematurely moving a child or moving a child who is awaiting residential treatment placement may be very destructive in that it would involve another new environment for the child prior to his long term placement. This type of shuffling of children is extremely confusing for them and seriously affects their sense of self and trust in others.

- Some nursery programs could be used to assess the parent-child interaction for the purpose of recommending the child be returned to his/her family or that proceedings should be initiated for termination of the parent-child relationship. When this is the basis of placement it is recommended that a time limit be established between the worker and nursery staff as to how long parental absenteeism will be tolerated before a decision to "pray for termination" to the juvenile court.

- A crisis nursery for six children ideally should have four bedrooms. Many of the children in the nursery had contagious diseases and separating children for sleeping and nap time would have been easier on the children and the houseparents.

- The kitchen and living room of the nursery were carpeted and the staff learned quickly that vinyl floors would have been easier to care for than the carpet. In addition, the staff recommends an upper oven and a frostless freezer and refrigerator.

- If a nursery program includes older age children, the staff suggests a basketball hoop and court area for the children. It is recommended that crisis nursery programs be located in a residential neighborhood and that the building have few identifying program characteristics. The less unobtrusive the building, the more likely the children will feel at ease and the more comfortable the parents will be in visiting their children.

- It is recommended that the staff of the nursery be assigned the tasks and responsibility of purchasing food, household items, and clothing for the children. It is further recommended that a petty cash system of funds be available to staff for the children's recreational activities and emergent medical needs.

Adaptability

Planning for continuing the Family Center Crisis Nursery Program was implemented prior to the closing of the nursery in April, 1977. The project director met with the Board of Directors, the program committee, and the Adams County Advisory Board for Human Services, Incorporated, a United Way agency. This agency and the grantee agency, the Adams County Department of Social Services, planned to enter into a contractual purchase of services agreement to re-open the nursery and to care for abused children in Adams County. Human Services, Inc. had agreed to the contract arrangement. Two months prior to the end of the project the grantee agency director and the executive director of Human Services, Inc. decided to delay the signing of the contract for ninety days.

The results of this decision were a delay in re-opening the nursery; a lack of continuity; a lack of project staff to assist in the orientation and training of new staff; and more importantly, the lack of an effective crisis care center for children. However, it is anticipated that a contractual agreement will be negotiated in the near future and the nursery will be re-opened. Parents Anonymous members and other interested lay and professional people are requesting that it be re-opened.

The Crisis Nursery Program, as it was operated at the Family Center, can be a very helpful part of a comprehensive child abuse program. Choices for placement of abused children are necessary in an effective service delivery system. A nursery provides for short term care that is complimented by child evaluations and treatment. Few treatment programs are available in most communities except for residential treatment centers, which are very costly and usually long term. Thus, if crisis nurseries with treatment programs were available for children of potentially abusive parents, and to mildly abused children, placement time could be lessened and more families could be reunited sooner.

Funding for nursery programs can be negotiated through social service departments under purchase of service contracts. In Colorado, Title XX funds are available for such programs. The funds for setting up nurseries could be obtained through local fraternal organizations, foundation money, or fund raising efforts. The Family Center Crisis Nursery Program received approximately $10,000 in materials and labor through the Westminster Kiwanis organization. Other communities in Colorado are experiencing similar kinds of support through other organizations.

THERAPEUTIC FOSTER CARE

Robert Mc Donald

Introduction

As originally conceived, the Therapeutic Foster Care Program was intended as an additional means of improving the generally underdeveloped area of treatment of the abused child. The lack of available resources for the treatment of children from abusive environments was identified as an area of concern by the authors of the original grant proposal. This concern was shared by project staff, and served as a motivating factor as the Therapeutic Foster Care Program was developed. This program area utilized the existing foster care structure within the Department of Social Services, and attempted to develop the therapeutic foster care concept out of that structure. The overall goal of this program area was to provide a therapeutic foster care environment for abused or potentially abused children who display behavioral problems, emotional problems or developmental lags. Objectives were defined to meet these goals and they are:

1. To provide a therapeutic home environment for the child until the natural parents are capable of caring for the child and meeting his physical and emotional needs.
2. To provide more appropriate parenting role models for the child.
3. To help meet the child's physical and emotional needs more appropriately.
4. To provide an environment in which the child can experience improvement in the areas of behavioral problems and developmental lags.

Selection of the Therapeutic Foster Care Home

There was one therapeutic foster care couple with one project social worker responsible for the program. The couple was chosen from among the new applicants to the Department of Social Services' foster care program. The Therapeutic Foster Care Program was explained to all of the new foster care applicants and the family that was selected expressed the most sustained interest in the program. The family was Anglo, middle class, and consisted of two parents and three male children ranging in age from three to seven years.

Training of the Therapeutic Foster Care Family

Prior to actually taking a child, the family received training around the etiology of child abuse, as well as the behavior and treatment of the abused child. The initial training provided by the project social worker spanned a six week period and involved weekly meetings with the family. During this time the family received training from other project staff, especially those involved in the child growth and development groups. Other community resources involved with child abuse were also involved in the training. This training, especially those aspects dealing with the treatment of the abused child, continued on a regular but less structured basis during the entire time the child was in placement.

Criteria for Placement

The child eventually placed in the therapeutic foster care home was chosen from the caseload of the Department of Social Services protective service unit. Department of Social Services staff had been advised of the

Therapeutic Foster Care Program, and were asked to consider possible appropriate referrals for the program from their caseloads. There was no difficulty obtaining support for this request as there was always a number of children from abusive environments exhibiting behavior problems in the home, the school, or the community who were in need of placement out of the home. The Therapeutic Foster Care Program was viewed as a much needed resource by the protective service staff.

The child chosen for placement was a six year old Anglo male. He shall hereafter be referred to as J. in this paper. J. was from a large, poor, multi-problem family which had been known to various social service departments throughout the state over a five year period. J. had an extensive history of physical and emotional abuse. He had been diagnosed several months earlier by a local children's diagnostic center as functioning at a mildly retarded level. His gross and fine motor development was approximately that of a three year old, as was his general affect and ability to relate to peers and adults. He was singled out by the natural mother as being the "problem child" of the family. The mother was asking for placement of J. because she admittedly could not handle his immature and disruptive behavior. He was placed in the therapeutic foster care home based on a court order with which the mother was in agreement and, in fact, requested.

Treatment of the Child in Placement

There were two primary sources of treatment for J. while placed in the therapeutic foster care home. The first, and most important, was the foster family itself. Secondly, the social worker assumed the role of therapist for J., and supervision of the therapeutic foster care family. The social worker at the school which J. attended also acted as a treatment resource.

While the foster family tried to incorporate J. into its structure and routine as much as possible, it was also acknowledged by all that J. possessed certain problems which warranted special attention. Those problematic areas in which the foster parents expended the most time and energy were: short attention span; hoarding of food; withdrawal behavior; fear of physical contact, especially adults; semi-autistic (for example, rocking) behavior; inability and/or unwillingness to join in with other children in outdoor activities; reluctance to share feelings; enuresis; nightmares, and generally disrupted sleeping patterns.

The foster family's therapeutic interventions around these issues created an atmosphere in which J.'s behavior and general affect improved considerably. Several areas were especially difficult for the foster parents to understand and deal with; such as nightmares, rocking behavior, reluctance to share feelings, and required more help from the social worker. Aside from focusing on the behavioral and emotional aspects of J., the foster family also paid considerable attention to his cognitive deficits. The foster mother took a special interest in helping J. improve his reading and writing skills. Over a period of five months he demonstrated improvement which was noted by the school which J. attended.

The project social worker spent a minimum of one hour per week with J. in the therapeutic foster care home. The social worker represented a link for J. with his natural family. Frequently the treatment time would be spent discussing J.'s feelings about his family, why he had been placed in foster care, how visits were going and other related issues. These therapeutic sessions would occasionally take the form of play therapy in which dolls or games were used to discuss feelings. The social worker would also utilize the technique of therapeutic story telling. He would help J. develop a story in which J. provided the major theme and most of the dialogue. This technique was especially helpful as J. expressed his feelings of fear at having been abused by his step-father, and his anger toward his mother for placing him in a foster home. J. would also use the sessions to discuss dreams or nightmares that he would not talk about with his foster parents. Exploring these dreams with J. and communicating the essence of them to the foster parents was helpful in enhancing the foster parents' understanding of J. and the many feelings he was experiencing.

The social worker would spend an average of two to three hours per week in the therapeutic foster care home. After an hour was spent with J., the remainder of the time would be spend with the foster parents, and occasionally with the children of the foster parents. There were often problematic or frustrating issues which the foster parents needed to discuss. It was somewhat difficult for the foster parents to understand why a child who looked very much like any ordinary child would have such a difficult and complicated emotional life. The expressions of these feelings would often involve anger or frustration regarding J.'s natural mother, especially after a home visit. The foster parents periodic discussions of their negative feelings toward J.'s natural mother with the social worker were essential to the success of the therapeutic foster care placement. An integral part of the therapeutic foster care concept was that there would be ongoing communication between the foster and natural families, and that the foster parents would develop into a modeling resource for the natural parents. One responsibility of the social worker was to facilitate this process.

Involvement with the Natural Family and the Family Social Worker

As there were problems with the natural family other than J., a family social worker from the Department of Social Services protective service division met with the mother on a regular basis. From the beginning of J.'s placement it was agreed that a basic goal would be to return J. back home. It was essential, therefore, that there be a close working relationship between the Family Center social worker and the social worker involved with the natural family.

The relationship in this instance worked very well. The two social workers communicated on a regular basis. During the last six months of J.'s one year placement the therapeutic foster care social worker met twice monthly with the family social worker and J.'s natural mother. Several times the foster parents were also involved in these sessions. They coincided with J.'s increased visits to the home of his natural family, and during these sessions the visits were discussed. They also served the purpose of keeping the natural mother informed of J.'s progress. One month prior to J.'s return home, and for several weeks afterwards, the therapeutic foster care social worker met with the family social worker and J.'s entire natural family to facilitate a successful reintegration into the family. This pattern of open communication was conducive to a more therapeutic atmosphere for J. as well as for his family.

As was previously mentioned, the foster parents were occasionally involved in the meetings with the social workers and the natural mother. Through these meetings and the communications around the scheduling of visits, J.'s natural mother came to view the foster parents as an ally and resource.

She frequently called the foster mother to discuss a visit. After J. was returned home, she would call to discuss alternative ways of dealing with his behavior problems.

Use of Collateral Resources

Since J. had a short attention span, significant developmental delays, and an overall limited cognitive functioning, he was quickly noticed by the school's special services staff. A close working relationship soon developed between the school, the therapeutic foster care social worker and the therapeutic foster care parents. Later, as the time drew near for J. to return home, the natural mother also became involved. The number and complexity of J.'s emotional and cognitive limitations necessitated frequent communication among those persons involved.

Based on a pre-placement diagnosis of mild mental retardation, J. was initially placed in a class for the mentally retarded and physically handicapped. It soon became apparent that with his new home environment and regular therapy sessions, J. was already functioning at a higher cognitive level, and making accelerated progress in his rate of cognitive development. This prompted consideration of a change for J. in his school situation. After much collaboration and discussion between the therapeutic foster care social worker and the school special service staff, J. was placed in a class for the emotionally disturbed, which was a more appropriate school placement for him.

Because of his disruptive classroom behavior, the school social worker also began seeing J. on a regular basis. Her primary method of working with J. was play therapy and he responded well to this additional therapy.

Another community resource which became involved with the Therapeutic Foster Care Program was the JFK Child Developmental Center, an evaluation and diagnosis center affiliated with the University of Colorado Medical Center. J. received neurological and psychological examination there primarily to rule out any possibility of an organic component being involved in his cognitive and emotional problems.

Outcomes of the Therapeutic Foster Care Program

After one year of placement, testing indicated that mental retardation was ruled out, and that J.'s problematic behavior was in no way organically based. He also made significant improvement in his cognitive development and in his fine and gross motor skills.

His behavior and overall emotional health improved considerably during the first half of the placement. During the second six months, however, as the time drew near for his return home and the frequency of home visits increased, his emotional state deteriorated. His functioning was almost comparable to his condition when he entered the therapeutic foster care home.

After his return home, J.'s mother was able to acknowledge that he was not mentally retarded, as she had previously believed. She also came to realize that J., perhaps more than any of the other siblings, suffered the effects of a long history of abuse, and that this had a dramatic impact on his growth and development. The family social worker has continued to work with the entire family and J. will continue in the school's special program for the emotionally disturbed.

This experience with the therapeutic foster care home has demonstrated that with the proper training and continuous support, a foster care situation can provide a therapeutic environment for even the most demanding of children with disruptive behaviors. The weekly involvement of the social worker with the therapeutic foster care family helped prevent any frustration or problems from getting out of control. It also helped enhance the family's understanding of the abused child, and its ability to cope effectively with the depression and anger which abused children will often exhibit. A therapeutic home environment of this sort might help prevent a particularly disturbed child from needing institutional care.

The regression which J. manifested, however, as the re-integration processes with his family intensified, was difficult for the therapeutic foster care family to accept. It caused them to doubt the effectiveness of their efforts, as well as to become somewhat pessimistic about J.'s future after he returned home. They perceived the investment which they had made in J. as being threatened.

Plans for the Continuance of the Therapeutic Foster Care Program

The Department of Social Services has expressed a willingness to continue the Therapeutic Foster Care Program on the same scale as it had been operated by the Family Center Project in that they are planning to establish one therapeutic foster care home and with one assigned social worker. Because of the department staff limitations, the time allocated for the program will be limited to two hours per week. A social worker from the department's foster care unit will be assigned to work with the therapeutic foster care home.

Issues

Systems Issues

Approximately 35 to 40 percent of the social worker's time in the Therapeutic Foster Care Program was spent advocating for J. with other systems, especially the school system. A lack of knowledge of the dynamics and effects of child abuse was occasionally manifested by some professionals working with J. This, along with a strong bias on the part of some against ever returning a child to parents who had abused or allowed him to be abused, sometimes made it difficult to meet J.'s needs within a therapeutic context. The amount of time necessary to deal with these peripheral yet important issues was not anticipated at the outset of the Therapeutic Foster Care Program.

Negative Feelings of Foster Parents Toward Natural Parents

This issue, which is often present in any foster care situation, was also present in the Therapeutic Foster Care Program. The emotional investment of the foster parents in J. often made it difficult for them to be objective when it came to maintaining the necessary relationship with the natural parent. Since this relationship was an integral part of the Therapeutic Foster Care Program, the feelings of the foster parents needed to be listened to and responded to by the social worker.

The Kind of Child Placed in a Therapeutic Foster Care Program

This issue relates to the advisability of placing a child from a multi-problem, chaotic family into a situation where he might improve in terms of emotional health and behavior, but where there is little chance of the natural parents changing, even with the benefit of therapy. J.'s natural parent did not change appreciably. It also appeared that as J.'s contact with his natural parent increased, his regressive behavior also increased. Some of his regression was no doubt due to his imagined rejection by the foster family and the confusion he must have felt by being exchanged between two families. However, the limited potential for change on the part of the natural parent also appeared to affect J. Perhaps, the natural parents should have a strong motivation to change before the child is placed in therapeutic foster care.

A Cost-Effectiveness Question

Approximately 10 percent of the therapeutic foster care social worker's total work week was involved in providing therapy to J.; providing training and support to the therapeutic foster care parents; regular contacts with the family social worker and the natural parent; and contacts with collateral resources. Might this be an inefficient use of staff time? Could the cost of such a program potentially impact a greater number of abused or potentially abused children if used in other ways?

If, however, the cost of placing a disturbed child in a Therapeutic Foster Care Program for one year is compared to the cost of keeping the same child for a similar time period in a children's institution, in all likelihood the Therapeutic Foster Care Program would represent a cost saving. While the weighing of these options and alternatives is necessary from a cost-benefit perspective, it should also be remembered that there is a dearth of resources available for the treatment of abused children. If, after further studies, therapeutic foster care does not prove to be effective, other possibilities must be explored.

Chapter Eleven

THERAPEUTIC DAY CARE

Mary Maroon and Linda Moomaw

Introduction and Goals

At the time that the Family Center grant was originally written, it was felt that there was a need for treatment of abused children. One of the initially conceived concepts for children's treatment was the idea of therapeutic day care. One of the services for children already existing and utilized to a great extent in the Adams County Department of Social Services was licensed day care homes. For this reason it was decided to incorporate the therapeutic day care concept into an already existing licensed day care home. The first goal of this program was to provide a therapeutic environment for children who had displayed behavioral or developmental lags as a result of abuse or potential abuse. The second goal of this program was to provide the parents of these children a place where they could learn more appropriate parenting skills. Finally it was hoped that this program could then be incorporated into the already existing social services child protection structure.

Objectives

There were five objectives for this program. Three of these objectives were to observe and evaluate the child, to provide the child with continuity of care until the parent could provide adequate care, and to develop an individualized and specialized program to meet the child's needs. The final two objectives were directed toward the parent, and they included providing the parent with increased parenting skills and providing relief for the parent.

Definitions

Therapeutic day care as implemented in this project can be defined as a licensed day care home in the community which provides a specific milieu therapy program for abused or potentially abused children under the age of six. The therapeutic day care mother needs to be someone who has had a positive parenting experience and has had some other experiences with children, particularly in day care or with special needs children. She should have some basic knowledge of the psychological and developmental issues with children and have the flexibility to use alternative methods of discipline. It is equally important that the day care mother be willing to be supervised and have the capacity to utilize other resources for learning.

Recruitment and Training

Since part of the concept of therapeutic day care was to use already licensed day care homes, the recruiting focused on names received from the social worker in the day care unit at the Department of Social Services. The day care worker sent to the project staff the names of licensed day care mothers that she thought might be interested in a specialized day care program. These mothers were contacted by phone and, if they expressed an interest in the program, an interview was scheduled. In all, eight day care mothers were interviewed by the two project staff involved in the therapeutic day care component. Areas focused on in the interview were the day care mother's past parenting experiences; experience with special needs children; the types of discipline used; their flexibility in learning new methods of discipline; their willingness to be involved in ongoing training; their concept of therapeutic day care; and what their expectations were in regard to the role of the therapeutic day care mother. For a list of questions see Appendix XIII. Of the eight day care mothers interviewed, two were finally selected.

Because there were only two day care mothers, it was difficult to provide a structured training program. Therefore, training was provided primarily by utilizing outside resources and by the individual project social worker during supervision with the day care mother. Some of the outside resources used were the National Center for the Prevention and Treatment of Child Abuse and Neglect, the Colorado Day Care Association Conference, and Forest Heights Lodge, a children's residential treatment facility that provided consultation. These resources provided information on such issues as: 1) the normal psychological and physical development of the child; 2) the major developmental milestones and problems that can arise from these periods; 3) identification and assessment of developmental lags; 4) developmental stimulation techniques; 5) control issues; limit setting and discipline methods; 6) problem solving with children; 7) affective and verbal communication with children; 8) the development of the abused child; and 9) how to use day care as a therapeutic tool with abused children.

During supervision, the project social worker addressed the above issues, but as they related to the specific children in the day care home. The focus of supervision was to help the day care mother understand the child's problems and behavior theoretically and also what techniques might be most appropriate. The social worker would also direct the day care mother to books and articles that would further her educational growth. Please refer to the bibliography. Besides these two resources, the day care mother was encouraged to attend the Family Center's research meetings and any educational activities provided by the Department of Social Services.

Implementation

Criteria

The children eligible for therapeutic day care ranged in age from one to six; had to have behavioral problems, emotional disturbances or developmental lags; and had to have been abused or in a potentially abusive situation. It was also decided that there would be no more than three children placed in one day care home and that any one child would need to be in the day care home a minimum of three days a week. Also, in order to be in compliance with state and federal day care standards, only one of the three children could be under the age of 2½.

These criteria were developed for several reasons. The age range was determined based on the thinking that abused children under the age of six were less visible to the community and had fewer outside resources than school-age children. It was also believed that it would be difficult to provide a therapeutic day care program for children in the first grade or above because they would only be available after school hours. The behavioral criteria were developed because the project staff assessed a need for a structured treatment program for children with these behavioral and/or developmental problems. It was also believed that a structured treatment program was more beneficial than the usual custodial day care. The three days a week minimum was decided on because it was felt that that time period was needed in order to provide a comprehensive program for each child and to effect change in the child's behavior. Because the staff initially did not know the range of problems that would be referred, it was decided rather arbitrarily that three children per day care home could be provided the maximum amount of individual care. It was for this same reason that it was also stipulated during the interviewing process that the day care mother could only take those children referred by the Family Center.

Over the course of the project, these criteria were slightly altered. The age range was changed to include only children between the ages of two and six. This occurred because problems developed with a one-year-old who was accepted for therapeutic day care. The developmental differences between the one-year-old and the older children were so great that the day care mother could not adquately meet the demands of the one-year-old and also attend to the other children. The other criteria that was changed was the maximum number of days required for the child to be in therapeutic day care. Because of the resistance from some parents, transportation problems and kindergarten schedules, it was found that the program needed to be more flexible. Therefore, some children were coming half days only and one child came only two days a week.

Referral Procedure and Selection Process

A referral form was developed by the project social workers. Please refer to Appendix IX. The family social worker was to complete the referral form and refer it to the project social worker. The project social worker and the therapeutic day care mother then reviewed the referral form to determine if the child were eligible for the program. In addition to the above criteria, the eligibility was also based on the ages of the children already in the day care home; the kinds of problems these children had; the types of difficulties the referred child had; and whether the day care mother felt she could work with this child. The project staff wanted to be careful not to refer to one home all children who were severely acting out or were extremely withdrawn. The project social worker also needed to take into consideration the day care mother's strengths and weaknesses and not place a child who would overwhelm her.

Once the child's eligibility was determined, a meeting was arranged between the family social worker, the parents of the child, the therapeutic day care mother, and the project social worker. This meeting focused on the parents' perception of the child's problems, how the parents had attempted to handle these problems, how the parents felt about the child coming to therapeutic day care, and what were the parents' expectations. The project social worker and the day care mother would then describe the program and what the expectations were for participation. This included negotiating with the parents how many days a week the child would be coming, the expectation that the child would be there on the appointed days, and what back-up arrangements could be made by the parent in situations of illness of either the child or day care mother. The parent was asked to call the day care mother if the child was going to be absent. Finally, it was explained to the parents that if the child appeared with unexplained injuries, the day care mother and project social worker would be required by law to report the incident to the Department of Social Services.

A second interview was arranged, usually within the same week, with the parents and the child. This interview was used to observe both the child's behavior and the interaction between the child and parents. This interview was also used to obtain further developmental history on the child and also to clarify any questions that had arisen since the first interview. After these interviews, if all parties were in agreement with the child being placed in therapeutic day care, the mother signed the day care agreement forms and medical forms, and the child entered therapeutic day care for the diagnostic evaluation.

Diagnostic Evaluation

The first two weeks of the child's placement was used as a diagnostic period. During this time the child was given formal psychological testing by the project's consulting psychologist. The day care mother also observed the child closely to assess the areas in which the child appeared age-appropriate, the areas in which there were developmental lags, and the ways in which the child interacted both with his peers and the day care mother. Areas observed were the child's socialization skills, language skills, gross and fine motor skills, and cognitive skills. To obtain some baseline data on the child, the day care mother completed the Family Center's Behavior Check List and the Semantic Differential forms every day. After all the initial data had been collected, the day care mother and social worker met to outline the areas of the child's behavior and functioning that would need to be treated and what the best techniques or approaches would be with the child.

Interpretive Session

At the end of this two-week diagnostic period, a meeting was arranged with the family social worker, the parent, the day care mother, and the project social worker. At this meeting, the project social worker interpreted the results of the evaluation, the areas in which the child needed help, and how the day care mother would provide this help. If all parties were in agreement with the treatment plan, the child would then continue in therapeutic day care.

Time Schedule

The selection of the therapeutic day care mothers took five months, from August, 1975, to December, 1975. The selection process took that long primarily because of the scarcity of day care mothers interested in therapeutic day care. Approximately fifteen names of day care mothers were received and, out of those, eight expressed interest. Each of these was interviewed once by the two social workers responsible for the therapeutic day care program, and two day care homes were selected after a final interview.

At the beginning of January, 1976, the first formalized training session began. This was a ten-week seminar on child development issues given by consultants from Forest Heights Lodge for day care and foster care parents from the Department of Social Services. At the end of January, 1976, the first child was referred and accepted into one of the therapeutic day care homes. Two more referrals were received at the end of March, 1976. These two referrals were accepted and divided between the two day care homes. (Refer to Appendix X.)

At the end of June, 1976, one of the day care mothers accepted another job and decided to terminate her position as a therapeutic day care mother. This coincided with the termination and referral of the child placed in her home. Between the end of June, 1976, and the beginning of October, 1976, four more referrals were received, and by the end of October, 1976, the remaining therapeutic day care home was filled. It took fourteen months from selection to full utilization. The program took that long to be fully implemented because of problems in the selection and referral process that will be discussed in the issues section of this chapter.

Children Accepted for Therapeutic Day Care

Eight children were involved in the therapeutic day care program. The ages of these children were as follows:

1	15	months	old
2	24	"	to 30 months
2	30	"	to 36 "
1	48	"	old
2	60	"	"

All of these children had at least one developmental lag, and most had two or three. The most common developmental lag was in language skills. These children either had limited speech, limited age-appropriate vocabulary, or incoherent speech. The second most common lag was in gross motor skills. Fine motor skills were age-appropriate for almost all the children. Cognitively, most of the children tested fairly close to the normal range. One child scored in the retarded range and thus had serious cognitive limitations.

Behaviorally, the children fell into two groups: those who were withdrawn and those who displayed destructive aggressive behavior. The withdrawn children preferred to isolate themselves from peer or group interactions and seldom initiated interaction with adults. They also tended to be the children who had difficulty defending their rights. They displayed passive aggressive characteristics, such as wetting or ignoring responses from adults or peers.

The aggressive children attempted to interact with peers and adults, but usually in a very provocative manner. This was displayed through temper tantrums, screaming, biting, kicking, hitting, throwing things at others, and destroying property.

Both these types of children suffered from a common problem, and that was the inability to use alternative means of expressing feelings and needs--not having appropriate verbal skills and usually not being encouraged to use skills they had. Most of the children lacked verbal means of expressing feelings. More importantly, many of these children really did not know how to play. Play is the most common way in which pre-school children express and work through their feelings and conflicts. This inability was a particularly serious limitation.

These behavioral characteristics also interferred with their interactions with peers and adults. Because of the inconsistent parenting they had experienced in the past, they lacked knowledge about how to get their needs met from people.

The children accepted for therapeutic day care had serious attachment difficulties. Most of these children had been abused as early as the end of the first year of life. Also, to provide relief to the parents, they had been passed around to friends, neighbors, relatives--anyone who would take them. As a result, these children did not develop the kind of bonding with one consistent parent which usually occurrs in the first three years of life. Behaviorally this was displayed in the children having a lack of trust in adults, poor eye contact, resistance to being touched or held, clinging behavior, lack of stranger anxiety, and a lack of preference for any one parenting figure. They soon learned that either severe withdrawal or destructive aggression was the only way to get attention. As a result, they either lacked or repressed the full range of behaviors that most children utilize to get needs met.

Scheduling

In order to provide a home-like atmosphere, no rigid schedule of activities was maintained in the therapeutic day care program. Usually the children would come to the day care home between 8:00 and 9:00 in the morning. As each child arrived, the day care mother would provide some quiet activity for them until all the children were present. During the first part of the morning, the day care mother would organize some group activity relating to the developmental or socialization skills. At mid-morning a snack would be provided for the children. After the snack the children were usually allowed free time to play outside or to play with a favorite toy or game. The day care mother also used this time to work individually with one of the children. Lunch would then be provided for the children between 11:30 and noon. Lunch was also a time that the day care mother would use to promote further socialization skills. After lunch, some quiet activity, such as a story, would be provided, then nap time began around 1:00 or 1:30. After the naps, the children again usually had some free play or individual attention until their parents came to pick them up. Most of the children were picked up between 3:00 and 4:00 p.m. On certain days the day care mother took the children on special outings, like to the zoo, the Children's Museum, or the park.

Therapeutic Day Care Program

Once the initial evaluation was completed, an individualized program was developed for each child in five main areas. These areas were to help the child to get his physical and emotional needs met; to help the child become developmentally age-appropriate; to modify those parts of the child's behavior that might be abuse-provoking; to provide more appropriate adult role models for the child; and to help the child relate more appropriately to his peer group. These areas were addressed in some way each week. In order to meet the physical needs of the child, each day the child was given snacks, lunch, and a nap. These three events were scheduled at regular times in order to provide some consistency for the children.

In the area of emotional needs, the day care mother attempted to identify feelings that the children were acting out through their behavior. These feelings of anger, sadness, frustration, and happiness were identified and labeled for the child, and the child was encouraged to verbally express these feelings. The expression of feelings was further facilitated by the day care mother maintaining eye-level contact with the child while speaking with him/her and by attempting to get the child to maintain eye contact during those interactions. These two techniques were used in order to ascertain whether the child understood what was being said and to encourage more appropriate attachment behaviors. Appropriate attachment behaviors were further encouraged by the day care mother assessing at any given point in time what the child was emotionally needing. Sometimes the child would want to be assured, given affection, listened to, empathized with, held, or was seeking limits. Because these children had difficulty verbally expressing needs, it was important that the therapeutic day care mother be able to differentiate the needs underlying many different kinds of behavior.

Becoming aware of the children's feelings and needs also helped to provide the child with an appropriate adult role model. In addition, the therapeutic day care mother attempted to give the child very clear messages about himself, his behavior, and his environment. The child was told what the limits in the day care home were and was given feedback on the consequences for his negative behavior on himself and others. The child was also given direct praise for age-appropriate behaviors and for behaviors that evoked positive rather than negative responses from his environment. The therapeutic day care mother also made sure that the expectations placed on the child were both age-appropriate and within the capabilities of the child. She also behaved in ways which modeled for the children how to appropriately get needs met, express feelings, and resolve problems.

The day care mother also encouraged more appropriate peer relationships. Structured social situations were designed to involve the children in group interactions. These group activities focused on such issues as patience and respect for others, self-responsibility, and appropriate problem-solving skills. The children were encouraged to respect other children's rights as well as their own rights, to share, and to accept responsibility for their own behavior and the consequences of their behavior. The therapeutic day care mother intervened only to either protect the child from physical assault or to maximize the children's problem-solving skills, and she tried not to resolve the problems for the children.

Both the individual interactions between the therapeutic day care mother, the child, and the peer group activities provided an opportunity to modify abuse-provoking behaviors. Some of the children entered therapeutic day care with some very specific abuse-provoking behaviors. The different techniques that were used to deal with these behaviors included behavior modification techniques, restraining techniques, problem solving techniques, and time out. Along with these techniques, the day care mother continued to focus on identifying and labeling feelings for the child, eye contact, and utilizing play activities and toys to help the children more appropriately express their feelings and problems.

Besides the abuse-provoking behaviors, all the children came into therapeutic day care with developmental lags. Each week the therapeutic day care mother would develop a theme for dealing with the developmental lags that was easily understandable by children of several age groups. The theme was also carried through activities designed to relate to the areas in which deficiencies occurred.

The following is an example of a theme and a number of activities that might be selected for any given week.

Theme: Farms and Farm Animals

Gross Motor Skills

Becoming animal characters - galloping horses, grazing cows, hopping rabbits - Farmer in the Dell (form circle, sing song, act out characters).

Fine Motor Skills

Cut and paste animals on farm background, color pictures of crops, animals, barns, etc., play "make-believe" with farm figures.

Verbal Skills

Read stories and poetry about farms and animals. Discuss animal sounds. Teach songs about farms and animals (Old McDonald).

Socialization Skills

Visit farm with animals, visit crop farm, explain farm-to-table cycle. Let children pick out fruits and vegetables from market. Let children make food from fruits and vegetables, make butter in jar.

Perceptual and Cognitive Skills

Discuss relative sizes--horses, big; sheep, smaller; chick, smallest. Discuss movement--horses gallop, pigs poke along. Colors--crops, animals. Match toy farm animals to sounds they make, ways they move, foods they eat.

Other themes that were used were bodies, medical care, jobs, weather, different countries' customs, foods, families, holidays, etc.

Besides the weekly program, the therapeutic day care mother developed activities that could relate to the child's particular emotional state.

Bored - color, paint, cut dolls, picture books, puzzles.

Restless - charades, go for walk, go to playground, impromptu field trips, T.V. (Sesame Street or Captain Kangaroo).

Angry - punching bags, climbing, running, play dough, water play, back rubs, puppets.

Withdrawn - music with homemade instruments, singing and dancing to records, charades, circle games (London Bridges, Ring Around the Rosie).

Some other activities provided by the day care mother that related to the child's emotional needs, developmental lags, and peer interaction were: body tracings and cutouts on long rolls of paper; scrapbooks with magazine cutouts; grooming techniques; making birthday cakes; making holiday decorations; feeding ducks; shopping trips; feelings charts using happy and sad faces; role playing; using toy telephones to talk about feelings; planting seeds; and using meals and snacks as time to discuss table manners.

Discipline and Control Issues

Where discipline was needed, the one major guideline was that no corporal punishment could be used. This guideline was established because corporal punishment was almost the only type of discipline these children knew. The staff was very concerned about decreasing the child's perceptions of adults as attacking, unpredictable, and dangerous. An essential part of the program was to help the child learn to respond to other forms of discipline and to gain internal controls rather than simply responding to external controls.

When the child came into the program, he was given two restrictions. These two restrictions were that he could not hurt himself, the other children, or the therapeutic day care mother; and he could not purposely destroy property. The fewer restrictions, the less likely it would be for the therapeutic day care mother and child to get into control struggles.

The focus of discipline in the therapeutic day care home was to teach the child more appropriate behaviors and to help the child accept responsibility for his behavior and develop internal controls. Two forms of discipline were primarily used in order to decrease aggressive, disruptive, acting-out behaviors. The first was to identify and label feelings for the child to teach him to gain verbal means of release for his feelings. For example, when a child purposely destroyed a toy, the therapeutic day care mother told the child that she knew he was angry and that it was okay to say he was angry rather than destroy the toy. Another form of discipline was to identify for the child the inappropriate behavior and teach the child a more appropriate behavior. For example, if a child kicked another child while arguing over a toy the therapeutic day care mother said, "We don't kick here. If you want the toy ask Johnny if you can play with it." In some instances, the therapeutic day care mother would identify the consequences of the child's behavior pattern for him. If the child were screaming, the day care mother might say, "Your screaming hurts my ears and I cannot understand what you are saying." As many of these interactions as possible occurred with the therapeutic day care mother having face-to-face contact with the child so that she could make sure that the child was listening to her and hearing what she said.

There was one primary technique used to decrease the number of control issues that arose. When a child was being disruptive or breaking a rule, the therapeutic day care mother would give the child two alternatives from which the child could choose. For example, if one child was disrupting two other children that were playing, the therapeutic day care mother might say, "Johnny, you can either go outside and play or color."

This prevented the therapeutic day care mother from constantly getting into control struggles with the children and allowed each child to take some control over his own behavior. It was important to make sure that both choices were desirable to the child.

In certain instances when the child did not respond at all to the forms of discipline mentioned above, the time-out technique was used. In these cases the child would be sent to the bedroom or told to sit in a chair for a few minutes until he could get his behavior under control. Often a kitchen timer was used so that the child knew that when the bell rang he could leave the bedroom or chair and resume his play.

With only one of the children, more restraining techniques were required. These techniques consisted of holding the child in the day care mother's lap so he could not move and telling the child that he would be released once he gained control over his behavior. During the time the therapeutic day care mother held the child, she would attempt to identify the particular feelings or needs that the child was acting out. Before the day care mother released the child she would ask him if he was under control and be able to tell what he was going to do after he was released. This technique was used sparingly and was continued only to the point that the child began to respond to verbal interaction. This took about two weeks.

These forms of discipline were not necessarily designed to eliminate undesirable behavior immediately. Rather, they were used to teach the children and help them integrate skills and behaviors that could be generalized to many different situations.

Role of the Natural Parent

The natural parents were involved in two ways in the therapeutic day care program. Approximately every three months, a meeting was arranged between the natural parent, family social worker, the therapeutic day care mother, and the project social worker. The discussions at these meetings centered around the progress the child was making, the problems that continued, and how the day care mother was dealing with the child. The natural parent was also asked what her perceptions of the program were and if she had noticed any changes in her child. This was also an opportunity to talk with the parent about different ways or methods in which she could relate to her child's particular problems. At this time an assessment was also made on the child's continuing in the program and what areas would continue to be focused on. All of the parents were informed about the meetings during the initial evaluation phase and were expected to participate.

Another benefit of therapeutic day care was involving the natural parent in weekly sessions with their children to help them learn more appropriate ways of interacting with their children. During the evaluation sessions each parent was asked if they wished to participate in weekly sessions which were designed to enhance their interactions with their child. If the parent agreed, a time would be scheduled weekly for the parent and child to come for two to three hours in the morning. One parent came twice a week. The therapeutic day care mother had the parent help with the activities for all the children and set up individual interactions between the parent and her own child. The focus of these sessions included both changing the parent's behavior toward the child and changing the parent's attitudes about child-rearing.

The activities with the parent included helping the parent see several options in dealing with undesirable behavior in her child; giving the parent some idea of what she could expect of her child developmentally, physically, and psychologically; and giving the parent some idea of the kind of activities the child liked. The parent was encouraged to participate in the child's activities in the therapeutic day care home so she could transfer that knowledge to other situations with her child. These activities included arranging situations where the parent and the child could interact positively, and the day care mother reinforced these interactions. This showed the parent cause-and-effect behavior so that the parent could get more consistent gratification from her positive parenting efforts. It also gave more confidence to the parent so she would not get discouraged before her efforts brought results.

The attitudinal teaching included helping the parent see and appreciate the unique qualities of her child. In helping the parent see that it was okay to be angry with their child; to verbally express that anger; and help the parent see that undesirable behavior is present in all children, these parents learned their child was not different from his peers when they acted out. The therapeutic day care mother also helped the parent realize that ways of dealing with children vary from person to person and with time and circumstances. Also, it was important to help the parent understand that children sometimes react to internal feelings and conflicts as well as to external events.

Of the seven parents that were asked to participate, four accepted, and two actually followed through. Although no research was completed on parental involvement, it was speculated that the two parents that did become involved in the weekly sessions had two common characteristics. First, both of these parents appeared to have a considerable amount of emotional investment in their children. Although their interactions with their children were often negative, they were constantly attempting to engage their children in some manner. Secondly, they also had some awareness of their own problems and could admit that at least part of the child's problems resulted from how they interacted with the child.

Those parents who did not participate in the weekly sessions appeared to be parents who felt that all their parenting difficulties were the result of their child's behavior problems; saw therapeutic day care as a means to control their child; or who were so depressed that they had no energy to invest in their child. Other kinds of treatment were offered to these parents through the social service department.

Role of the Family Social Worker

The involvement of the family social worker was believed to be a very important component in the success of the therapeutic day care program. For a child to be accepted into the therapeutic day care program, the family social worker was asked to become involved in three ways. First, in order to prevent miscommunications, the family social worker was asked to participate in the evaluation process and the quarterly evaluation sessions. Second, it was felt that the children would make more progress if the parents were attempting to resolve their own personal problems through therapy with that worker. Therefore, the family social worker was asked to meet with the parents at least twice a month.

It was felt that it would be most effective if the parents were seen weekly, but because of the high caseloads, this was not always possible. Third, once certain needs of the child were identified, the family social worker was expected to make the appropriate referrals for the child. This would include referrals for speech and hearing evaluations, psychiatric evaluations, and medical evaluations.

Role of Other Staff Members with Therapeutic Day Care

During the course of the project, several other staff members provided services to therapeutic day care. The Family Center nurse was the primary medical consultant for the therapeutic day care home. The therapeutic day care mother utilized the project nurse on an ongoing basis in assessing any medical problems that the children had. She also assessed any injuries that were suspected to be the result of abuse. Where it was suspected that a child might need a more specific medical evaluation, such as a neurological examination, the project nurse did a medical and developmental assessment of the child. If it were determined that a further medical evaluation was needed, the project nurse would set up the appointment.

The therapeutic day care mother also coordinated programs with the Crisis Nursery houseparents in those situations where the child was both in therapeutic day care and the Crisis Nursery. During the course of their stay in therapeutic day care, two children were also placed in the Crisis Nursery due to abuse by a parent. The children were continued in therapeutic day care to provide some continuity in their treatment program. The therapeutic day care mother and the houseparents usually were in contact with each other daily to discuss the behavior of the child, how they dealt with it, and what other methods could be used with the child. They also utilized each other as consultants for other children. This relationship provided them with stimulation and support.

At one point during the program, an attempt was made to provide a volunteer to help the therapeutic day care mother one or two times a week. The coordinator of the project called high school teachers who taught child development classes and asked if any students would be interested in volunteering. One student was interested, but only came for two weeks. After this, there was no success in obtaining a volunteer.

However, during the last six months of the therapeutic day care program, the project's case aide came to the therapeutic day care home one morning a week. The case aide helped in planning, in group activities with the children, and in supervising the children while the therapeutic day care mother worked individually with a child. The case aide also helped supervise the children on outings.

Role of the Therapeutic Day Care Social Worker

There was one project social worker working with each therapeutic day care home. Each social worker spent an average of five hours a week working on the therapeutic day care program. In general, two and one-half hours a week were spent supervising the therapeutic day care mother. The supervision took place at the day care mother's home. One and one-half hours a week were spent observing the children. One hour was spent in coordination and referral activities. Initially it was thought that the social worker would be doing direct treatment with the children in therapeutic day care. However, after a few months of the program and before any individual treatment with the children was initiated, it was decided that it would be more efficient and effective to utilize the social worker as a consultant and supervisor. Working with abused children can be very difficult. The abused children in therapeutic day care homes sometimes evoked feelings of frustration and anger in the therapeutic day care mother. In order for her to be able to meet the needs of the children appropriately, it was very important that the therapeutic day care mother be able to ventilate her feelings to the therapeutic day care social worker and feel that she would be listened to in an objective, nonjudgmental manner. [illegible] that reason, it was believed that the alliance needed to be primarily with the therapeutic day care mother rather than with the children. Thus, if a child needed individual psychotherapy, he was referred to outside resources.

The two primary functions for the therapeutic day care social worker were coordination and supervision. The coordination function focused on two areas. One area included enhancing communications between all individuals involved with the child in therapeutic day care. This meant communicating with the houseparents, the project nurse, the family social worker, Denver University Speech and Hearing Clinic, schools, and other medical and mental health personnel. Because the child's feelings and behaviors were not isolated from his environment, it was essential for the therapeutic day care social worker to know what other kinds of services were being provided to the child and what events were occurring in the child's life that might have significant impact on him. It was very important for the therapeutic day care social worker to relay this information to the therapeutic day care mother so that she could develop programs complementary to the other services received by the child and so that she could better understand the behavior that the child was displaying. Direct communications between the therapeutic day care mother and others involved in the case was encouraged.

The second area focused on assessing what other services were necessary to meet the needs of the child and facilitating the appropriate referrals. Once the need assessment was made, it was important for the therapeutic day care social worker to get this information to the family social worker so that the referral to the appropriate resource could be made as soon as possible.

Supervision of the therapeutic day care mother focused on three areas. First, the primary emphasis of supervision was on enabling the therapeutic day care mother to obtain a theoretical understanding of the normal psychological and physical development of children, behavioral manifestations of normal development, and the psychological and behavioral deviations which occur in pre-school-aged abused children. The therapeutic day care social worker discussed with the therapeutic day care mother both the development and timing of milestones such as walking, talking, or toilet training, and the concomitant psychological development occurring within the child. For example, it was important to know that toilet training normally can occur between the ages of seventeen months and three years. Equally important to know, however, is that controlling or not controlling his bowels is the child's first attempt at asserting his independence from parents, who up to that time have had total control over him. When the therapeutic day care mother understood that other normal behavioral manifestations of this pursuit of independence are temper tantrums and refusal to obey parents, she could see these behaviors as chances to allow the child some control and mastery over himself rather than as signs of stubbornness that needed to be eliminated.

These children suffered psychological lags which manifested themselves in behaviors that were not age-appropriate. Sometimes gratifying the needs underlying these behaviors allowed the child to move on to the next stage of psychological development. For example, a child who has not been allowed by his parent to show age-appropriate dependency behavior might display excessive clinging behavior. This clinging behavior needs to be gratified before a child can become more appropriately independent. It was essential that the therapeutic day care mother understand the meanings of these behaviors in order to determine which ones needed to be discouraged and which ones needed to be encouraged and gratified. Furthermore, it was important to have the therapeutic day care mother meet those emotional needs so that the child could begin to direct his energy toward developmental skills.

Although specific techniques of dealing with a child were discussed, it was much more productive to focus the supervision on the theoretical understanding of the child and his behavior and then help the therapeutic day care mother develop ways of relating to the child.

The second focus of supervision was on helping the therapeutic day care mother gain a theoretical understanding of the abusive parent. Much of the frustration for the therapeutic day care mother was caused by working with the natural parents. Two characteristics of the abusive parents were particularly difficult to cope with for the therapeutic day care mother. One was the tendency for abusive parents to obtain gratification from the unhealthy parent-child relationship and the negative behaviors of the children. Because of this, the abusive parent did not always positively reinforce the child's new behaviors, and in some cases, either subtly or overtly tried to undermine the child's more positive responses. Secondly, abusive parents often perceived suggestions on different ways of relating to their children as attacks on their parenting skills and, therefore, were often resistant to change. These two characteristics were manifested by parents being irregular in bringing their children to the therapeutic day care home; bringing their children later than the appointed time; criticizing the therapeutic day care mother on her ways of dealing with the child; and discounting the therapeutic day care mother's suggestions. Because of these behaviors, the therapeutic day care mother experienced feelings of anger, frustration, disappointment, and inadequacy. It was necessary to help the therapeutic day care mother understand each individual parent and what behavior the therapeutic day care mother might expect. Interpreting the behaviors and responses of the abusive parent seemed to decrease the therapeutic day care mother's personalizing these behaviors and increased the ability of the therapeutic day care mother to cope with her feelings.

The third aspect of supervision was to provide support to the therapeutic day care mother. Abused children and their parents have developed family patterns to meet their needs. These patterns manifest themselves in behaviors that do not promote healthy growth for either child or parents. For many reasons, these family patterns and behaviors are very difficult to change. It was very important to help the therapeutic day care mother maintain realistic expectations when working with abused children and abusive parents. Sometimes the therapeutic day care mother would be discouraged and frustrated over the slow progress the child or parent made and feel as if she were not doing an adequate job. It was important to focus on the emotional impact she was having on the child or parent and to point out changes that the day care mother was not able to observe because of her closeness to the situation.

Another way that the therapeutic day care social worker needed to support the therapeutic day care mother was by including her as much as possible in activities with other staff members. Working as a therapeutic day care mother was very isolating. In order for the therapeutic day care mother to feel a part of the treatment team, the therapeutic day care mother was encouraged to have direct communication with other staff members, to attend staff development training sessions, to attend the project research meetings, and to provide direct written and verbal input into the planning for each child. Also the therapeutic day care mother was given opportunities to attend conferences and seminars with the project paying the expenses. Since continued stimulation seemed to be one of the major incentives to being a therapeutic day care mother, it was very important to encourage and provide these opportunities.

Cost Analysis

Part of the process of implementing the therapeutic day care program was the determination of financial reimbursement to the therapeutic day care mother. In order to reduce resistance on the part of the natural parents and insure that the day care mother would be paid, it was decided that the therapeutic day care mother would be reimbursed by the Adams County Department of Social Services from the regular day care payments. In August of 1975, the regular day care payment from the department of social services was $3.50 per day per child. The average payment per child per day for private day care was $4.50. It was decided that payment for therapeutic day care would be $5.00 per child per day. This was decided on for four reasons. First, the day care mother was being asked to take only the children referred from the department of social services, so she could not supplement her income with private day care clients. Secondly, the children placed in these homes were special-needs children requiring more time and energy than the non-abused child would require in a regular day care home. Third, the therapeutic day care mothers were required to participate in extra training above and beyond the regular day care requirements. Finally, it was decided that $5.00 would not be an unreasonable amount for the department of social services to provide for children in a therapeutic day care setting.

During the course of the program, payment for regular day care went up to $4.50 per day per child. Again for the above reasons, the payment for therapeutic day care was raised to $6.50 per child per day. It was determined that the cost to the department of social services for a month, based on three children at $6.50 per child per day for five days a week, was $370.00. In reality, because of the absence rate of the children, the highest amount paid in any one month to the therapeutic day care mother was $300.00. Also, certain educational toys costing $50 were ordered and paid for out of project funds.

The expenses to the therapeutic day care mother for providing the services were also determined. On the average, food costs for three children were $42 per month, including lunches and snacks. When parents were involved in the therapeutic day care program it cost approximately an extra $1.11 per day. Supplies that the therapeutic day care mother used for the children cost approximately $37 a year.

The cost of therapeutic day care, compared to the cost of other services to children provided by the department of social services, was quite low. The cost per child per two months in the Crisis Nursery was $1,108.00 The cost per child per month in foster care was $409.00, and in a residential treatment facility it was $840.00. The cost per child per month in therapeutic day care was $130.00. If a department of social services financially invested in three therapeutic day care homes with three children per home, it would cost them $1,170 per month. Therefore, to serve nine children in therapeutic day care, it would cost a department of social services anywhere from $3,681.00 to $7,380.00 less per month to serve a comparable number of children in any one of the three 24-hour care facilities. It is further speculated that if therapeutic day care were used as part of a prevention program, it would save a department of social services money in the long run by decreasing the need for children to be placed in a 24-hour-care facility.

Issues

Problems in Recuriting

During the recruiting process, certain issues arose that resulted in some of the day care mothers eliminating themselves as potential therapeutic day care mothers. One of the issues involved the financial reimbursement by the department of social services. It was stipulated that the therapeutic day care mother could only take children from the department of social services and that there would be a maximum of three children per home. The therapeutic day care mother would be reimbursed five dollars per child per day. At the time of recruitment, the average rate for private day care was $4.50 per child per day, and many day care mothers were charging six or seven dollars per child per day. Many of these mothers were also licensed to care for up to six children. Some of the day care mothers felt that they could not financially afford to give up private day care to become a therapeutic day care mother. Even when the payment was raised to $6.50 per day per child, it was still under the amount that some of the day care mothers were receiving for private day care.

Another issue was the day care mother's concern about the amount of support that they would receive in working with children who had severe behavior problems.

The third issue involved the day care mother's fears that the abused children's behavior would have a negative impact on their own children. The day care mothers were particularly concerned that their children would imitate aggressive and destructive behaviors.

Finally, some of the day care mothers felt that they would be unable to relate to or work with abusive parents.

Problems in Obtainable Referrals

One of the major problems after the therapeutic day care home was established was obtaining enough referrals. The number of referrals actually received was far below the number of referrals anticipated. There appear to be two primary reasons for the limited number of referrals. The first reason seems related to the lack of treatment resources for children prior to the initiation of the project. Social service workers did not seem to be as aware of the need and effect of specialized treatment for pre-school age children. Typically, social service departments have only had staff to treat abusive parents and children's treatment was a new experience for them. Thus, as in most new programs there was a need to educate and encourage utilization of this program.

The second reason was the lack of transportation. The therapeutic day care program required that the parents provide transportation. Some of the social workers stated that they had children who would be eligible for therapeutic day care but that the families lacked transportation.

An increase of referrals could be accomplished by:

1. Providing in-service training to the department of social services staff on the importance of treating children; how to do a developmental assessment of a pre-school-age child; which children and parents would be eligible for therapeutic day care; and what kinds of services the therapeutic day care program provides.
2. Asking the nurse or intake social worker to make a developmental assessment of the identified abused child during the intake process and recommending therapeutic day care to the family social worker for those children who appear appropriate.
3. Attempting to recruit therapeutic day care mothers in high referral areas so that the problem of transportation can be decreased.

Resistance of Parents

Almost all the parents experienced ambivalence toward the therapeutic day care program. In general, the abusive parents experienced a loss of self-esteem in admitting that their children had problems and needed help.

They perceived either suggestions for improving or actual improvements in their child's behavior as indictments of their parenting skills. Even parents who were very invested in their children and the program experienced this. When ambivalence was extreme, it took the form of parents withdrawing their children from therapeutic day care. Two mothers did this. In one instance the mother and child had been court ordered to use therapeutic day care. Once the court order was dismissed, she withdrew the child. She did place the child in another day care facility. In the second case, the mother was so threatened by the developmental lags which her child was found to have that she also withdrew her child.

However, the majority of the parents displayed their ambivalence by being very sporadic in bringing their children to therapeutic day care. The sporadic attendance of these children made it difficult to provide a consistent program for the child or to make very rapid behavior changes. In those cases where the parent was also involved in the therapeutic day care program, and in those specific instances where transportation was provided, the attendance of the child was much better. The time involved in the evaluation and acceptance of the children in the program was an issue. This procedure takes approximately three weeks. The program was purposely designed this way to prevent therapeutic day care from being used as a crisis center or from being used as a dumping ground for parents who simply wanted relief.

Outcome

Between January of 1976 and May of 1977, eight children were referred and accepted into the therapeutic day care program. One other child was referred but his parents left the state before he could be entered into the program. The average age for a child in therapeutic day care was 3 years. The average length of stay was five months. Termination status of the eight children in therapeutic day care was as follows:

Two children had planned terminations and were referred to day care centers.

One child had a planned termination and was referred to a residential treatment facility.

One child had a planned termination and was referred to a summer camp and also to a SLIC (Severely Limited Intellectual Capacity) classroom.

Two children were withdrawn by their parents.

One child was terminated as an age-inappropriate referral.

One child was terminated because of lack of parental cooperation.

During the course of the therapeutic day care program, behavior forms were completed on each child. From these research forms a fairly consistent pattern emerged for a majority of the children. Initially, the children displayed primitive, aggressive, and acting-out behavior. After a period of time, a relationship of trust appeared to develop between the children and the therapeutic day care mother. As this relationship became solidified, the children went through a period of regression which was displayed in dependent and clinging behavior. Eventually, the child's aggression or anger re-emerged, but this time the behaviors were less primitive and more constructive. This pattern can be illustrated by giving an example of the typical behaviors displayed during each of the periods.

During the initial stage, when the children were exhibiting severely aggressive or acting out behaviors, some of the more typical behaviors displayed on the Family Center's Telephone Survey of Child's Behavior were: --yelled at parent

--shrieking or screaming

--yelled at peer

--cried, whined, or pouted

--hit parent

--hit another child

--temper tantrums or strong outbursts of anger

--intentionally threw or broke things, destroyed property or household furnishings

--argued with or talked back to adult

--did not obey

--seemed always on the go

--didn't accept help when offered

--refused to play with other children

--refused to interact with adults

--avoided being touched

--stared into space; "seemed in a world of his own"

--hurt self intentionally, biting, head-banging, etc.

These behaviors indicated a great deal of rage and anger on the child's part which was generalized to most interactions. It also indicated the child's inability to focus his energy into more age-appropriate behaviors and activities.

During the second stage, when a trusting relationship developed with the day care mother, there was a general decrease in the aggressive acting-out behaviors outlined above. There were also less extreme behaviors indicated on the Family Center Semantic Differential Form. The patterns in the data led to the conclusion that as the child began to develop trust in the therapeutic day care mother his anger decreased, and his energy was focused in a more appropriate way. Some behaviors that occurred more frequently during this time were:

--sought out company of adults
--sought out company of other children
--obeyed request of adult
--engaged in an activity for longer than five minutes
--laughed, giggled, sang, clapped hands, other happy behavior
--put toys away

During the third stage, around the middle of the stay in therapeutic day care, the child regressed and displayed more dependent clinging behaviors than aggressive acting-out behaviors. Some of the behaviors displayed during this time were:

--clung to parent or followed parent around
--asked for help for something he could do himself
--jealous over attention paid others
--sought out physical contact
--sought out company of adults
--sought out company of other children
--acted babyish for his age
--preoccupied with food

Abused children have very high expectations placed on them by their parents and are expected to be independent at a much too early age. The above behaviors seem to be manifestations of needs that were neither encouraged nor met by the natural parent. It appears that as the trusting relationship develops, the child begins to feel reassured enough to request, in behavioral terms, that these needs be met. If the therapeutic day care mother gratifies these needs to be dependent and nurtured, the child can then move on to the next stage.

During this next stage, the child began to show more age-appropriate behavior, and his anger sometimes re-emerged, but in a more verbal, less physical manner. Behaviors that were most likely to be seen at this stage were:

- --yelled at parent
- --yelled at peer or sibling
- --argued with or talked back to adult
- --made threats, including third-person threats such as, "That monster is going to kill you."
- --swore or cursed

Other behaviors that continued during this stage were:

- --asked for something he could do himself
- --sought out physical contact
- --sought out company of adults
- --sought out company of children
- --obeyed request by adult
- --engaged in one activity for longer than five minutes
- --laughed, giggled, clapped hands, other happy behavior
- --put toys away

Unlike the totally aggressive acting-out behavior seen when they were first in the program, children at this stage engaged in both verbally aggressive behavior and behavior that was socially cooperative and would be positively responded to by most adults.

Seven of the eight children were given formal psychological testing. The Bayley Scale of Infant Development was administered to children under the age of 2½, and the McCarthy Scale of Children's Abilities was administered to children over 2½. Only four of the seven children were retested. Because of this very limited sample, no definitive outcomes could be determined from the formal psychological testing. However, three general statements can be made:

1. In general, the General Cognitive Index did not change appreciably for the three children tested and retested on the McCarthy test.
2. The testers observed that, in general, the children's ability was greater than their test performance showed.
3. The testers concluded that the low scores the children received were, at least in part, the result of the children's emotional problems.

Recommendations

Because of the limited number of children and parents that were involved in therapeutic day care, the program was unable to provide specific statistical tests for outcome measures. However, the project has developed a model for therapeutic day care from which certain patterns have emerged which indicate a need for further research with a larger population. Specific recommendations for future day care programs are:

1. The length of treatment for the child placed in therapeutic day care should be increased. As stated in the outcome section, even though the length of time in therapeutic day care was only an average of five months, a certain behavioral pattern emerged for a majority of the children. It is speculated that if the children stayed in the therapeutic day care home longer, these children would continue to move on to a decrease in clinging/dependent behavior with a comcommitant increase in independent and age-appropriate behaviors. The hypothesis is that this would be accompanied by a decrease in diffuse anger allowing the child's energy to be focused in increasing language, cognitive, and motor skills.
2. A profile needs to be developed of the type of parent that is most likely to benefit from involvement in therapeutic day care. It appears that two characteristics which need to be assessed in accepting a parent for involvement in parent participation

aspects of the program is the parent's psychological investment in the child and the parent's awareness of his or her problems in parenting. It would be important to look for other factors that might occur in parents who could successfully use therapeutic day care.

3. A profile needs to be developed of the type of child who would be accepted in therapeutic day care. Success with a particular child appeared to depend not so much on the child's specific behavioral or personality characteristics, but on the condition. Those children that showed the most positive changes in behavior came from families that displayed abuse rather than neglect dynamics, whose parents were consistently in treatment themselves, and who had stability in some areas of their life. It appears that this type of family is more likely to allow the child to maintain his new positive behaviors. Those children for whom the program was least successful came from families that displayed neglect rather than abuse dynamics, whose parents were sporadically in treatment, and who had instability in all areas of their family life.

4. More research is needed to determine the difference in success of treatment between children whose parents agree to become involved in therapeutic day care and children whose parents refuse. Initially it was believed that it was essential to involve the parents in the therapeutic day care program in order to make any significant impact on the child. However, with the difficulty in getting parents involved in the program, it was decided that the focus would be on trying to provide some positive adult interaction and stimulation to the child. Further research on a larger population needs to be conducted to determine if therapeutic day care can make a significant impact on a child whose parent is not actively involved.

5. The primary focus of supervision needs to be in helping the therapeutic day care mother understand the psychological needs of the child. The three most important characteristics that need to be

encouraged in the therapeutic day care mother are the ability to be consistent with the children, the ability to gratify the children's dependency needs, and to tolerate the children's regressive behaviors. It is speculated that the therapeutic day care mother needs to respond to and meet the child's emotional needs in order to enable the abused child to channel enough energy into developmental areas to achieve age-appropriate cognitive and motor development.

CLINICAL OVERVIEW AND TREATMENT EFFECTIVENESS RESEARCH ON CHILDREN AND PARENTS

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Introduction

A major goal of the Family Center Project was to determine effective treatments for abused and potentially abused children and abusing adults which could be provided within the context of a public department of social services, as well as to provide an assessment of the types of children and adults identified as needing project services. Because most studies on abused children have involved hospital based samples of severely abused children, the project staff considered this a unique opportunity to provide data on a community based sample of children who ranged from categories of potential to severely abused, and parents who similarly spanned the categories of potential abuser to actual abuser.

In May, 1975, the Family Center Project received a special grant of funds from the U.S. Department of Health, Education and Welfare, Office of Child Development to embark on this research. Three consultants were hired as part of this effort: a research psychologist from the University of Colorado, who had an extensive background in child abuse research with the National Center for the Prevention and Treatment of Child Neglect and Abuse; and two psychology doctoral students, one hired to provide developmental testing for the children and the second student to assist in the programming and analysis of the data received. This group worked as a team with the full time project researcher to develop the evaluation plan in conjunction with the project staff.

A number of distinct evaluation groups were identified, and these included:

1. Children placed in the Family Center Nursery - ages birth through 12. (56 children were included in this group.)
2. Children birth through 12 on the project caseload who were the designated abused or potentially abused children but who were not receiving treatment intervention (only their parents were receiving treatment services by project staff). (23 were included in this group.)
3. Children birth through 12 who received direct treatment services by project staff. These services inlcuded play therapy, individual psychotherapy, group therapy, family therapy, therapeutic day care or foster care placements, and crisis nursery placement while on the project case load. (29 children were included in this group.)
4. Parents, including abusers, potential abusers and their non-abusing spouses who received treatment intervention by Family Center staff. This treatment included individual therapy, group therapy, couples/marital counseling, family therapy, and child management classes. (36 parents were included.)

Hypothesis were developed by the research team, and these were tested through the administration of standardized development tests, a variety of behavior forms and a self-esteem form for the children; and through the administration of a marital questionnaire, self-esteem form and parent-child interaction form for the parents. These forms and the process through which they were choosen are fully discussed in the following section on methodology. Data from the tests and forms were collected at intervals over the course of the child and parent's association with the project.

Specific hypothesis to be tested included:

1. Children admitted to the Crisis Nursery and to the Family Center caseload will show deficits in their intellectual functioning and

their self-esteem when compared to their normal age peers. The extent and type of these deficits will be related to the child's age, sex and severity of abuse. It is hypothesized that older children will have more deficits than younger, boys more deficits than girls, and the more severly abused children will have more deficits than the mildly abused children. Both the groups of actually abused children will have more problems than potentially abused children. Changes will occurr with project involvement and the extent of the change will be related to type of intervention offered, age, sex and severity of abuse. It is hypothesized that children given direct treatment and longer term help will improve more than children given only Crisis Nursery placement or where parents only are in treatment, younger children will improve more than older children, girls more than boys and potentially abused children more than actually abused children.

2. Behavioral and affective problems may exist, but there is no normative data with which to compare project children. Therefore, behavior and affective profiles and patterns will be described for the project children at intake. It is hypothesized that older children will have more severe problems than younger, that boys will have more severe problems than girls, and the more severely abused children will have more problems than the mildly abused children. The potentially abused children will have fewer problems than the actually abused children. Changes resulting from their project involvement will be described. These changes will be related to age, sex, severity of abuse, and the type of intervention provided to the children, in the same fashion as described in Hypothesis 1.

3. Parent-child interaction problems will exist in these families. Older children will have more problems interacting with their parents than younger, male children more proolems than females, and actually abused children more problems than potentially abused. Older parents will have more problems interacting with their children than younger, males more problems than females, and actual abusers

more problems than potential abusers. These interactions will improve with project involvement. The extent of the improvement will be a function of the child's age (with younger improving more than older), sex (with girls improving more than boys), severity of abuse (with potential improving more than actual), and type of intervention offered to the child. Improvement will be affected by the parents' age (with younger improving more than older), sex (with females improving more than males), abuser status, i.e., potential, actual or spouse of abuser (with potential improving more than actual), and involvement with treatment (with longer term involvement leading to more progress).

4. Parents will have problems with impulse control, isolation and expectations of children at the beginning of treatment. The extent of their problems will be related to their sex, age, and abuser status. It is hypothesized that men will have more severe problems than women, older parents will have more severe problems than younger parents, and actual abusers will have more severe problems than potential abusers, or their non-abusing spouses. These problems will improve with treatment. It is expected that women will improve more than men, that actual abusers will improve less, and that younger parents will improve more than older parents. It is also expected that the greater the involvement in treatment, the greater the improvement.

5. Parents will have marital adjustment and self-esteem problems. These will improve with treatment, and the extent of changes will be related to age, abuser status and treatment involvement in exactly the same fashion as described under Hypothesis 4.

A further assessment of the progress of parents and children within the Family Center caseload was captured through a case rating system developed for use by the social work staff working with the clients. The rating system, which is described in Appendix XII, provided a before treatment and after treatment rating for all parents and children served by the Family Center staff.

These ratings measured the extent of client progress in a variety of areas as assessed by the clinician and provide a further assessment of beginning and end points for these cases.

The following sections of this report provide a description of the methodology of the research, populations studied, outcomes analysis, issues relating to conducting this type of research program and a special section dealing with developmental testing of the abused child.

Research Methodology

Development of Research Forms - A Collaborative Effort

In May, 1975, the Family Center staff began a series of meetings with their research consultants. The purpose of these meetings was to develop a treatment evaluation program for the children and parents served by the project. An attempt was made to be as broad and inclusive as possible in suggesting areas which might be important to assess as part of the evaluation. The sources of the ideas about assessment were varied and included: knowledge of the research literature on child abuse, project staff's experience in working with abusive families, and research experience in related areas. Out of these meetings, general categories of variables emerged which were considered important for the research staff to assess. These variables were separated into two groups: assessment of abused children; and assessment of abusing or potentially abusing adults.

In looking at the children, the following types of assessment were considered important: 1) children's behaviors including provoking or acting out behaviors; role reversal behaviors and withdrawal behaviors (ranging from shy to withdrawn to regressed on a continuum of increasing severity); 2) the child's developmental and intellectual deficits; child's self-esteem (because the reported self-esteem problems in abusing parents, the children's self-esteem was designated as an important area to assess); and 3) child's mood states, as a measurement of personality style.

A parallel list of important areas to measure for parents was developed which included: 1) marital adjustment; this was on the assumption that the parents' marital adjustment affected their behavior with their children; and 2) parent's self-esteem. Based on a literature review, it was hypothesized that the parent's self-esteem would be lower than in a non-abusing group.

There were also demographic variables which were important to assess for both the parent and child. Such data included age, race, sex, abuse abuser status (potential, actual or non-abuser), and marital status for parents; and age, race, sex, abuse and placement for the child. This data was needed in order to determine the characteristics of the population the project was serving.

A final category of data determined to be an important one was an assessment of the interaction between parents and their children. It was hypothesized that child abuse was often, if not always, an interaction process. It was hoped that one of the major effects of the treatment delivered through the Family Center would be an improved parent-child interaction. A way to assess this interaction was needed.

The next phase of the research effort required that the research staff determine whether or not any measures existed which would be appropriate for the kinds of data collection mentioned above. The easiest aspect of this search was in the area of standardized tests to assess a child's developmental level. In order to cover the age range of the children that the Family Center dealt with, three standardized tests were selected: the Bayley Scale of Infant Development (age range 2-30 months), the McCarthy Scales of Children's Activities (age range 2½-8½ years), and the Wechsler Intelligence Scale for Children (ages 6-16). For the area of self-esteem, the Self-Esteem Questionnaire, developed by James Hoffmeister, Test Analysis and Development Corporation in Boulder, Colorado was selected. This questionnaire could be completed by both children and adults.

No test which measured the other areas of concern were found which satisfied the project's strict criteria for selection. Instruments were needed which were flexible enough to cover several areas of children's behavior and functioning in a variety of different environments. It was important for the staff to feel comfortable with the research forms, so that they would be motivated to collect the data the forms required. The forms had to be brief and easy to complete, requesting no unnecessary information. Finally, forms were required which allowed data collection from several different information sources so that the effects of rater bias could be minimized and the project staff could be relieved of some of the responsibility for data collection.

Given the above considerations, a program of instrument development was begun the summer of 1975. An initial pool of items was obtained by input from the Family Center staff in each of the major content areas. The consulting psychologist contributed items based on knowledge of the revelant research literature and theoretical formulation of the abuse situation. The research personnel led discussions about various format possibilities and collection schedules in meetings with the project staff. During these meetings each item was discussed with regard to its clarity of meaning, its relevance to the types of clients being served by the project and the assessment objective, and the ease with which it could be rated. At this point, first drafts of six data collection forms were developed and discussed. A series of revisions followed as items were added and deleted and different formats were pretested By August, 1975, a two-month trial period began during which project staff used the forms to collect data on the clients in their caseload. In September, 1975, another series of meetings followed in which the data collection forms were revised.

The forms which were developed by this process included: 1) the Family Center Telephone Survey of Children's Behavior (TS), a 49-item scale asking about the presence or absence of specific child behaviors which the social workers and Crisis Nursery houseparents felt would be most important to assess; 2) the Family Center Semantic Differential Form (SD), a 29-item scale which allowed the worker, or other staff to rate children on many different dimensions, each anchored at the extremes by opposite adjectives; 3) the Family Center Child's Interaction with Parents (CIP), a 25-item scale which assessed the quality and nature of the parent-child interaction; 4) the Family Center Child's Adjective Check List (CACL), a 36-item scale on which the children (five years or older) could indicate the degree to which they experienced a variety of moods and feelings; 5) the Family Center Marital Adjustment Questionnaire (MQ), a 61-item questionnaire which contained items from several different marital questionnaires reviewed by the Family Center consulting psychologist and staff, assessing areas of marital adjustment important for couple's functioning, and 6) the Family Center Demographic Code Sheets, one for the parents (Parent Code Sheet - PCS), and one for the children (Child Code Sheet - CCS), on both of which a variety of identifying and demographic material was noted. A summary of all the forms and tests, along with the frequency of data collection, the respondents, and people responsible for the data collection, is presented in Table 1. Copies of the questionnaires are contained in Appendices IV, V, and XI.

It is appropriate to discuss the time consuming process of instrument development which has been described, because it is unusual in research of this nature for researchers to work so closely with the treatment staff of a project during the research instrument development and planning stage. The traditional program evaluation paradigm is one in which some independent evaluation group decides how to evaluate the program and informs the treatment staff that they will collect certain data with a form provided them. This leads to predictable difficulty between research treatment staff of a program. Lack of communication, lack of understanding and mutual appreciation, and inefficiency in data collection are common outcomes of this situation. By including treatment staff in the research enterprise from the very beginning, it was possible to avoid the antagonism that often characterizes the research-treatment relationship. The instruments developed were understandable, and were clearly relevant to this particular project. Rather than being "outsiders" checking on the treatment staff, the researchers were an integral part of the whole team. The treatment staff's obvious investment in the research effort led to better, more conscientious data collection. This cooperative atmosphere eliminated the passive-aggressive, ostensibly compliant type of data collection that sometimes occurs in large program evaluation efforts.

The collaboration between research and treatment staff was not merely a beginning-of-project phenomenon. Throughout the project period there was a legitimate expectation on the part of the treatment staff that the research staff would be able to provide clinically relevant information from the data collection forms to help with case management. In an effort to meet this expectation, monthly meetings were held between the research and treatment

TABLE 1

SCALES AND TIMETABLE

Scale	When Will Data Be Collected	Data Will Be Collected From	Data Will Be Collected By
Self-Esteem Questionnaire for Parents	Beginning of case three months one year or termination	Parents	Social Worker (Parents will complete form themselves and will be given results i.e. where they stand in relation to other adults.)
Marital Adjustment Scale	Beginning of case three months one year or termination	Parents	Social Worker
Parent/Child Interation Scale	Beginning of case six months one year or termination	Social Worker based on Observations	Social Worker
Telephone Survey of Child's Behaviors	Beginning of case monthly for one year	Parents/Foster Parents	Volunteer: Parents/foster parents should be given a copy of this scale so they know the kind of questions on it. Persons collecting data will pre-arrange with the parents the phone date. If no home phone, go to home if ok with parents

TABLE 1 (CONT'D)

SCALES AND TIMETABLE

Scale	When Data will Be Collected	Data Will Be Collected From	Data Will Be Collected By
Child"s Adjective Check List (CACL)	Beginning of case six months one year or termination	Children five years of age and older	Social Worker
Semantic Differential	Beginning of case six months one year or termination	Social Worker based on contact with child	Social Worker
Self-Esteem Questionnaire For Child	Beginning of case six months one year or termination	Children five years of age and older	Psychological tester in September, 1975 Social Worker in January, 1976 in Aug 1976 Psychological tester
Psychological Testing	Beginning of case one year	All children	Psychological tester

staffs at which the research data for identified case(s) was collated, conceptualized, and reported back to the service staff. A typical meeting would include the presentation of some background information by the case worker, a report on the results of the child's developmental testing by the psychological tester, a report of the analysis of all of the child's research forms, an analysis of the parent's marital adjustment questionnaire, and their self-esteem data, and finally, case consultation and case planning based on all the presentations. These meetings were useful and enlightening to both the treatment staff and the research staff. The social workers were able to use the data presentations and the case consultation to plan and deliver better services to their clients, while the researchers were able to explore the clinical uses of forms that had been designed with that function in mind. The meetings also served to remind the caseworkers of the importance of collecting timely, accurate data on their cases. The meetings became a mutually beneficial exchange of perspectives. It is worth noting here that this kind of exchange between treatment and research groups is the exception in projects of this sort, rather than the rule. The usual complaint about research teams is that researchers always take and never give anything back. Through the provision of feedback, the project research team tried to avoid the image of collecting data which disappeared until final report time.

Psychometric Properties of the Research Forms

Each of the research forms that the project staff developed tried to tap several different dimensions of client functioning. For the TS, SD, and CIP, there were a sufficient number of completed forms to enter each form into an empirical cluster analysis in order to determine what areas of client behaviors and functioning the forms could measure. On the MQ and the CACL there were not enough completed forms to enter into this procedure. For these two forms, the consulting psychologist and the research technician developed face-valid clusters of items which satisfied a variety of clinical and psychometric criteria. The resultant cluster structures and the items that comprised each cluster are presented in Tables 2 - 5. The results for the marital questionnaire are presented in the section in which this questionnaire is discussed. The cluster structures reported in Tables 2 through 5 show that each of the forms measure several different dimensions of behavior and functioning, and that each form makes a unique contribution to the total understanding of a particular client. They are not, however, without overlap. Thus, there is a child acting-out cluster on both the Semantic Differential and the Telephone Survey, and an Active cluster on both the SD and the CACL. Except for the overlapping clusters, the inter-cluster correlations for the children's forms were very small and nonsignificant.

In an effort to discover whether there were some common profiles of scores on the TS, SD, CIP and clusters, a second order cluster analysis was performed using the BCTRY Cluster Analysis Package. The 17 clusters were grouped by this procedure into four "super clusters." Table 6 reports this new grouping.

Children's scores on these new "super clusters" were inspected, and four score profiles were identified which occurred with some minimum frequency. This identification was accomplished by the O-TYPE subroutine of the BCTRY package. These score profiles and the types of children they represent are presented in the next section.

TABLE 2

CLUSTER STRUCTURE FOR THE TELEPHONE SURVEY OF CHILD'S BEHAVIOR

Cluster #	Cluster Name	Item #	Item
1	Shy	38	Fearful of new situations or people.
		39	Was timed, overly shy
		30	Cried or got upset when parent left
2	Acting Out	12	Shrieking or screaming
		8	Temper tantrum or strong outburst of anger
		5	Hit parent
		3	Cried, whined, or pouted
		7	Intentionally threw or broke things, destroyed property, household furnishings
3	Passive/ Aggressive	15	Refused to interact with adults
		16	Avoided being touched
		17	Refused to play with other children
		49	Refused to eat
4	Role Reversal	21	Acted like a little adult or parent
		22	Overly helpful to adults
		23	Protected other siblings or peers
		24	Didn't accept help when offered
5	Seeking Interaction	32	Sought out physical contact
		34	Sought out company of adults
		35	Sought out company of children
6	Poor Peer Relations	2	Yelled at peer or sibling
		6	Hit another child
		31	Jealous over attention paid to others
		37	Acted in a manipulative way with peers

TABLE 3

CLUSTER STRUCTURE FOR THE SEMANTIC DIFFERENTIAL

Cluster #	Cluster Name	Item #	Item
1	Warm	23	Open, trusting
		27	Trusting
		11	Friendly
		15	Relates well to me
		20	Warm, affectionate
		12	Likeable
		14	Happy
2	Acting out	25	Defiant, disobedient
		4	Stubborn
		28	Prone to anger
		-19	Difficult to discipline
		5	Temperamental
		-16	Doesn't relate well to peers
3	Active	1	Active
		8	Aggressive
		2	Alert
		29	Bright
		-18	Fearless
4	Poor Concentration	3	Easily frustrated
		22	Impatient
		6	Distractible

TABLE 4

CLUSTER STRUCTURE FOR CHILD'S INTERACTION WITH PARENTS

Cluster #	Cluster Name	Item #	Item
1	Good Interaction	20	Parents responded to child's needs by doing the appropriate thing
		23	Parent's expectations of child seemed realistic
		19	Parents seemed to perceive what child needed when he behaved in certain ways
		21	Parents set limits I considered appropriate
		17	The parent successfully communicated feeling to child
		15	The child was successful in pleasing parent
		16	The child successfully communicated feeling to parent
		18	Parent and child seemed emotionally close
2	Provoking Child	11	Child teases or fights with sibling
		12	Sibling teases or fights with child
		8	Child deliberately provokes parent's anger
		6	Child ignores the parent
		9	Child persists when told to stop behavior
3	Abusive Interaction	25	Corporal punishment occurred and was harsh or inappropriate for child's age
		24	I observed harsh punishment of child for minor infraction
		4	The child appears afraid of parent
		10	Child appears to expect punishment
		5	The child resists physical closeness

TABLE 5

CLUSTER STRUCTURE FOR CACL

Cluster #	Cluster Name	Item #	Item
1	Positive	1	Happy
		21	Everything will be all right
		27	Likeable
		29	Cheerful
		31	Hopeful
		38	Important
2	Upset	2	Mad
		4	Sad
		5	Ready to Fight
		13	Lonely
		16	Upset
		24	Nervous
		25	Hopeless
		26	Angry
		30	Bad
		35	Down in the Dumps
3	Scared	10	Scared
		11	Helpless
		15	Like running away
		18	Afraid
		19	A burden to my folks
		22	Frightened
		23	Something bad might happen
		34	Sick
4	Active	3	Full of pep
		7	Wide Awake
		20	Active
		-33	Calm, peaceful
		37	Excited

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TABLE 6

"SUPER CLUSTER" STRUCTURE FOR ALL FORMS

Super Cluster #	Super Cluster Name	Test	Cluster Name
1	Acting out	SD	Acting Out
		SD	Poor concentration
		CIP	Provoking child
		TS	Acting out
2	Upset and Scared	CACL	Upset
		CACL	Scared
3	Outgoing and Healthy	SD	Active
		TS	-Shy
		SD	Warm
4	Abusive Situation	CIP	Abusive interaction
		CIP	Provoking child
		TS	-Role reversal

Clinical Picture of the Child at Intake

At the time of intake, initial data was collected on the children using the TS, SD, CIP, CACL, Self-Esteem Questionnaire, and standardized developmental tests. The data on the developmental tests (McCarthy, Bayley, WISC) is presented in a separate section. In this section the other intake data is summarized.

Twenty-eight children, ages 5 to 12, were given the self-esteem questionnaire at intake. When compared to the age-adjusted scores of non-abused children, the abused children looked about the same. Three of the children (11 percent) had low self-esteem scores, 12 children (47 percent) had middle-range scores, while 11 children (42 percent) had high self-esteem. These children were more similar to their non-abused peers than their parents were to their non-abusing peers.

Behaviorally, the children could be described by their score profiles on the "super clusters" previously described. At intake, 35 of the 81 children fit into one of four identified score profile groups. These four profile groups, along with their mean scores on each of the four "super clusters," are presented in Table 7.

These profiles identify some of the commonly described types of abused children. They can be understood as a typology of some of the common effects of child abuse. The first score profile has been named, "acting out and abuse," and was characterized by scores which indicate high acting out, high abusive situation, and low outgoing-healthy behavior. The most common profile has been called., "withdrawn," and was characterized by a minimum of acting-out behavior and the absence of an abusive situation. The third profile is called, "outgoing and healthy," since it was characterized by

TABLE 7
"SUPER CLUSTER" SCORE PROFILES *

Profile Name	Number of Children at Intake	Mean** Acting out Score	Mean Upset and Scared Score	Mean Outgoing and Healthy Score	Mean Abusive Situation Score
1. Acting out and Abuse	9	42.4	46.5	56.1	56.7
2. Withdrawn	14	60.2	46.4	47.8	44.0
3. Outgoing and Healthy	7	49.6	48.2	42.2	53.6
4. Upset and abuse	5	48.2	62.8	46.8	57.1
Total	35				

*The scoring key for these clusters is as follows: Acting out - low score = more acting out; upset and scared - high score = more upset; outgoing - low score = more outgoing; abusive situation - high score = more abusive situation

** Standardized scores $\bar{X} = 50$, SD =10 high amounts of outgoing and healthy behavior. The last profile which was identified was called "upset and abuse," and is characterized by scores which indicate that the child was upset and scared, and living in an abusive situation.

The score profiles (called O-TYPES) were approximately equally distributed by age, sex, and severity of abuse as rated on the Severity of Abuse Index. All the withdrawn O-TYPE children were found in the Crisis Nursery, as shown in Table 8.

TABLE 8

O-TYPE DISTRIBUTION BETWEEN FAMILY CENTER CASELOAD AND CRISIS NURSERY

O-Type	Acting Out & Abuse	Withdrawn	Outgoing & Healthy	Upset & Abuse	Total
Crisis Nursery	3	14	1	2	20
FC Caseload	6	0	6	3	15
Total	9	14	7	5	35

This distribution may be understood by observing that the Crisis Nursery houseparents were the adults that the withdrawn dchildren were interacting with, as noted on the CIP. This should account for the low abusive situation scores for these children, as well as the predominance of withdrawn behaviors. The children were likely to show less misbehavior at first in this new environment. This phenomenon was called the "honeymoon period" by the Crisis Nursery houseparents, and was a fairly common occurrence.

Perhaps the most striking finding is that 46 children had score profiles which fell into no consistent patterns. This demonstrates that there is no one effect of abuse on the behavior of children. Many children react to their particular abusive environment in ways idiosyncratic to their own personality. This finding emphasizes the importance of planning individual treatment programs for each child depending on the child's particular situation, reactions, and problems. The data which was gathered at intake was also examined to see if there were any differences on initial data between boys and girls; between children who remained in their own home and children who were removed from their home; and between children who received various degrees of abuse as measured by the Severity of Abuse Index.

Sex

The only significant sex differences at intake were that boys showed more acting out behavior as measured on the SD $(t=-2.73, p<.009)$ and were more frequently provoking as measured on the CIP $(t=-1.97, p<.05)$.

Removal From Home

Children who were removed from their home and were placed in the Crisis Nursery were compared to children who remained at home. This analysis showed that Crisis Nursery children were significantly less provoking with the Crisis Nursery houseparents than were the other children with their natural parents, as measured on the CIP. The children who were left at home were rated as more active on the SD than were their Crisis Nursery counterparts. The Crisis Nursery children were observed to have better concentration (as measured on the SD) than were the children left at home. On the TS, two significant differences were noted. The Crisis Nursery children were rated by the houseparents as seeking more interaction than the children left at home as rated by their

TABLE 9

INTAKE DIFFERENCES BETWEEN CRISIS NURSERY AND CASELOAD CHILDREN

	x on CIP* provoking	t	p	$\overline{x}$ on SD** active	t	p	$\overline{x}$ on SD** poorcon	t	p	$\overline{x}$ on ts** seekinter	t	p	$\overline{x}$ on ts** PPR	t	p
Own Home (n-26)	2.94	3.54	.001	2.64	-2.57	.01	3.30	-2.07	.05	1.45	2.00	.05	1.56	-2.30	.03
Crisis Nursery (n-28)	2.28			3.47			4.11			1.20			1.74		

* high score means more of behavior measured by this cluster

** low score means more of behavior measured by this cluster parents. Finally, the Crisis Nursery children were rated as having better peer relations than were the children left at home. These findings are reported in Table 9.

Severity of Abuse Index

Children with various types and severities of abuse were compared on their cluster scores (CIP, TS, SD, CACL) at intake using a one way ANOVA. The only significant effect found was that sexually abused children (N=2) were rated significantly less active on the SD than all other children. This effect was particularly powerful, as can be seen in Table 10.

TABLE 10

SIGNIFICANT DIFFERENCES BETWEEN CHILDREN GROUPED
BY ABUSE INDEX

Abuse Index	Severe & Moderate	Mild	Sexual	Potential & Emotional
X or SD Active	2.67	2.57	6.10	3.00
N =	11	6	2	36

$F_{(3,51)}=6.8$
$p<.001$

Comment on Initial Differences

When groups of children were measured who had quite different personal characteristics (i.e., sex) quite different histories (i.e., Severity of Abuse), and were in quite different environments (i.e., own home versus Crisis Nursery), one would expect that they might show quite different scores on the initial data collection instruments. The two significant sex differences which were reported can hardly be considered surprising, and can easily be accounted for with the ususal "boys-will-be-boys" explanation. The differences between the own home group and the Crisis Nursery group must be understood in the context of who was the respondent for much of the data. For the Crisis Nursery houseparents were the adults the children were interacting with, as well as the major data collectors. For the own home children, the natural parents were usually the ones with whom the children were interacting and they were also the ones to provide the data collected on the TS. Three explanations can be given for the differences found. First, the two groups might differ because of some differentiating characterological or personality differences. Second, the differences might reflect situation specific adaptive behaviors to radically different environments. Lastly, the differences might be the result of different response biases between the two groups of adults who rated the children's behaviors. At this point there is no definitive way of deciding between these three alternative explanations. The following speculations can be made. When asked for information about their child's behavior, parents, who have come to the attention of a social services department because of their abusive behavior, might be inclined to portray the child very negatively in an effort to justify their own abusive actions. The Crisis Nursery houseparents might have been able to be more objective in rating children's behavior, since they had no such history to justify. This difference between the respondents might account for the Crisis Nursery children looking significantly better on two of the TS clusters (Seeking Interaction and Poor Peer Relations).

The other differences might be due to different reactions on the part of the children to very different environments. Crisis Nursery children were rated as less provoking, less active, and less distractable than the children left at home. This might be understood as the children's adopting a "wait-and-see" attitude in a new, strange environment.

The most likely explanation for the differences between these two groups would be one which included all three possible sources mentioned before, different adults rating different children in different situations.

Finally, there was the finding that children who suffered sexual abuse by their parents were significantly less active at intake. At this time this finding must be considered suggestive, at best, because of the very small number of sexually abused children (n=2) in the sample.

The finding that the project children did not differ from the normative grade school population in self-esteem was contrary to the hypothesized difference.

All of these analyses help to highlight a point made earlier, namely that there appear to be no consistent, common effects of abuse on children's behavior. Individual assessment and treatment planning are clearly more appropriate than is any attempt to understand or treat these abused children based on untested generalities.

The finding that the behavior problems found in potentially abused children were not different from actually abused children at intake points up the need for offering services to these children. The frequently articulated hypothesis that actually abused children have more problems than potentially abused children received no support from the project children's behavior profiles at intake.

Outcome Analyses for Children

Client Rating Scales

One important way to determine client change over the course of treatment is to ask the social workers to rate improvement. Three Family Center research forms were developed for this purpose: the Child Improvement Form (CI), the

Adult Client Improvement Form (ACI), and the Parent/Child Interactions Improvement Form (PCI). (Refer to Appendix XII.) These forms allowed the social workers to rate their clients on a variety of dimensions. Each client was rated twice, once to indicate pretreatment level of adjustment, and once to indicate posttreatment level of adjustment. These scores were weighted according to a predetermined judgment about their importance with regard to overall client functioning.

The pre- and post- weighted ratings were subtracted to produce client change scores. On each of these 3 forms, larger difference scores indicate more client improvement. Negative difference scores are possible and indicate that a client was worse, in the opinion of the social worker, at the end of treatment than at the beginning of treatment. The change scores were residualized for the comparisons between groups, so that any significant differences found were not artifactually due to the differences between the groups before treatment.

The Child Improvement Form

The Family Center social workers completed the Child Improvement Form on thirty seven of their caseload children. They related the child's functioning with respect to four different reference groups - Peers, Parents, Adults and Therapist. At the beginning of treatment, the thirty seven children as a group, had an average score of 85.4 (with 60 indicating "minimal progress" and 120 indicating "fair progress") and at the end of project intervention the average score was 99. The children gained, but not enough to indicate they were making even fair progress by the end of the project's involvement. However, every individual item change score and every reference group total change score was significantly different from zero (no change) at the p=.05 level of significance, at least. Means, standard deviations, maximum and minimum score and significance levels for each reference group and a grand total are presented in Table 11.

TABLE 11

CHILD IMPROVEMENT FORM
DIFFERENCE SCORES

	X	SD	MAX	MN	N	Z	P
Peers	14.45	11.48	48	0	37	7.45	.001
Parents	17.19	10.67	40	0	37	9.80	.001
Adults	9.68	5.81	23	-1	37	10.13	.001
Therapist	12.66	5.70	25	2	29	11.95	.001
Total (Average of Above Scores)	13.48	8.19	32	-1	37	10.02	.001

While there were certainly children who did not change, or who only changed minimally, it was the social worker's judgment that on the whole, caseload children did improve in the areas assessed by the Child Improvement Form. Furthermore, they improved significantly with all the reference groups of interest.

Given that the group of caseload children, as a whole, improved in the eyes of the social workers, the next question to be asked is whether there was differential improvement between various subgroups of children. The total population of children was broken into subgroups on the basis of several different variables. These comparative analyses are presented below.

Sex. There were nodifferences between scores of the boys and girls on the adjustment scores before treatment. Improvement scores on the Child Improvement for boys (n=28) and girls (n=7) were compared in a t-Test. There were no significant differences between the tow groups on any of the total reference group scores. Both boys and girls improved from beginning to end, by not differentially. The small differences which were noted all favored the girls.

Treatment. When the direct treatment group (n=18) was compared to the group which received no direct treatment (n=17) on their adjustment ratings at the beginning of treatment, there were some differences. Children who received direct treatment had more problems relating to their parents than did those children not given direct treatment. They had more difficulty relating in ways which gave them positive social reinforcers from parents; relating in an age appropriate, independent fashion with parents and displaying self-esteem and confidence around parents. Around other adults, the children selected for treatment had more difficulty relating in a genuine, spontaneous, non manipulative manner. By the end of treatment there were significant differences between the two groups; and, although both groups improved, there were no significant differences in their residualized gain scores.

Thus, children chosen for direct treatment had more problems with their parents at the beginning of treatment than children not selected to receive direct treatment. Children improved on all scales by the end of the project whether or not they received direct treatment.

Severity of Abuse. Prior to treatment, there were unexpected and consistent differences between groups on the basis of severity of abuse. Three groups of children were formed on the basis of the Abuse Index. Group 1 consisted of severe, moderate and sexually abused children (n=10), group 2 included mild abuse, emotional abuse and failure to thrive children (n=5), and group 3 included potentially abused children (n=20).

The severely abused group 1 children were rated by the clinicians as consistently doing better at the beginning of the project than were the potentially abused or the mildly abused children. The potentially abused children were consistently rated as having adjustment scores a bit lower than severely abused children, with the mildly or emotionally abused children having scores much lower than both the other groups. The differences reached significance in 19 of the 25 pretreatment ratings, with the main contribution to the significance of the differences coming from a comparison of the mean ratings of the severe with the mild group. The severely abused group was rated as relating significantly more genuinely and non-manipulatively with peers, parents, adults and therapists. For all the other rated items, the severely abused group was rated significantly better in relating to all adult groups, with the exception of self-confidence displayed around the parents. Although all groups had problems, the relative superiority of the severely, moderately and sexually abused children was the opposite of the hypothesis. When examining gains at the end of the project, the severely abused children consistently gained more than the other two groups, even though they had started off better and their gains were residualized. Their gains reached significance on variables involving relating to peers and parents in a genuine, spontaneous and non-manipulative manner.

This is another finding which documents the previous results that, in this sample of project children, potentially and mildly abused children are not better adjusted than severely abused children. In fact, the mildly abused children looked worse, and gained less by the end of the project. Potentially abused children needed help as much as any other group of abused children, as there were no significant differences in social workers ratings of their adjustments at the beginning of their involvement between these children and their actually abused peers.

Length of Time in Caseload. The entire group of children was divided into four groups, depending on how long they were carried on a worker's caseload. Group 1 was on the caseload six months or less (n=5); group 2 was on the caseload between seven and twelve months (n=9); group 3 between thirteen and eighteen months (n=10); and group 4 was on the caseload longer than eighteen months (n=12). There were no significant differences between the groups at the beginning of treatment. There were two significant differences between the four groups on improvement scores. The longer the time on the caseload, the more progress in relating to peers and also, the more genuine, consistent, etc. the relationship to adults.

Age of Child. Two groups of children were formed; 0 - 8 (n=21), and 9 and up (n=35). At the beginning of treatment, the younger children had consistently better adjustment ratings on all scales, and this difference reached significance in 16 of the 24 items and the total scale score.

The younger children had significantly greater gain scores than the older on attempting to relate to parents and attempting to relate to the therapist. The older children gained more in feelings of confidence in relating to the therapist.

O-TYPES. O-TYPES refers to a classification of children on the basis of their behavioral profile at intake. (For a more detailed account of the O-TYPING procedure see Section - Behavioral Profile at Intake.) Fifteen children had both O-TYPE classifications and Children Improvement ratings. These fifteen children fell into three O-TYPE categories; acting out abused (n=7); outgoing healthy (n=5); and upset abused (n=3). These three groups were compared on their Child Improvement total ratings for each of the four reference groups; peers, parents, adults and therapist. The three O-TYPE groups all improved during the course of the project but not differentially so. What small differences there were between the three groups showed that the upset abused O-TYPE improved somewhat more than the other O-TYPES, while the healthy outgoing O-TYPE improved less in the judgment of the social workers. Of course, the healthy outgoing children did not need to make as much improvement to function well, so this difference is in the expected direction.

Summary of Child Adjustment at Beginning of Project and Improvement Ratings

There was no support for the hypothesis that boys would have more problems at intake than girls. Likewise, there was no support for the expected difference at intake between actually abused and potentially abused children. The severely abused children had the best adjustment at intake. The younger children had better adjustment ratings then the older, and this was in the hypothesized direction.

The severely abused group gained more through treatment than did the mildly or potentially abused group. There was no consistent relationship between age and improvement, as in some ways, the younger children gained more and in other ways the older children improved more. There was a consistent, but not significantly, larger gain for girls than boys.

Caseload children improved from intake to the end of the project whether they received direct services or only their parents received intervention.

Thus, there was overall improvement in children's ratings, but very little difference in improvement based on any of the variables hypothesized to make a difference.

The Adult Client Improvement Form

The Family Center social workers completed the Adult Client Improvement on forty-four adults in their caseloads. Each client was rated twice on nine different dimensions, one rating for the client's beginning functional level and one rating of functional level at the end of treatment. These ratings were weighted according to a predetermined judgment as to their particular importance to client functioning. Pre-ratings were subtracted from post ratings to obtain difference scores for each client on the nine questions. At the beginning, the average rating was 9.8, or less than minimum progress (a score of 13 indicated minimal prgress). After treatment, the average was 24, with 26 being the score indicating fair progress. The Family Center social workers rated their clients as significantly improved on all scales (i.e., with change scores greater than 0) over the course of treatment. These results are presented in Table 12.

In a series of analyses which parallel those described for the Child Improvement, the parent group was separated into various subgroups to see if this overall improvement was differentially reflected by different groups. These analyses are described below.

Sex. At the beginning of their treatment, females had better adjustment ratings than males on all 10 scales, and significantly better ratings on impulse control, use of support systems, and the total score. Improvement ratings on female adult clients (n=21) were compared to male adult clients (n=15) on the changes they made on the nine Adult Client Improvement items and a total score. The female clients improved more then the male clients on all ten

TABLE 12

DATA ON ACI CHANGE SCORES (n=44)

ITEM	x	SD	MAY	Min	7	P
1). Awareness of need	1.36	0.78	3.0	-1.0	11.56	<.001
2). Own needs separate from childs	0.89	0.78	2.0	-1.0	7.51	<.001
3). Awareness of childs needs	1.09	0.94	3.00	-1.0	7.74	<.001
4). Translate awareness to behavior change	1.14	0.73	3.0	0.0	10.23	<.001
5). Impulse controll assertiveness	5.27	2.96	12.0	-4.0	11.82	<.001
6). Uses suport systems	1.07	0.82	4.0	0.0	8.68	<.001
7). Initiates relationships	0.77	0.77	2.0	0.0	6.61	<.001
8). Initiates activities	0.95	0.94	4.00	-2.0	6.73	<.001
9). Maintain mature relationships	0.77	0.57	2.0	0.0	9.09	<.001
Total of items 1-9	13.96	7.02	27.0	-4.0	13.18	<.001

* Weight = 4

TABLE 13

DATA ON PARENT/CHILD INTERACTION FORM DIFFERENCE SCORES

ITEM	Mean	S.D.	Max	Min	7	p
1. Abuse stopped	2.67	2.17	6.00	0	9.88	<.001
2. Parent Listens to child	0.97	0.84	4.00	-1.00	9.32	<.001
3. Parent reaches out	0.89	0.76	3.00	0	9.38	<.001
4. Child reaches out	0.80	0.74	3.00	0	8.66	<.001
5. Mutually positive and nurturing	0.58	0.71	2.00	0	6.49	<.01
6. Parent interaction relates to childs needs	0.91	0.73	3.00	0	9.96	<.001
7. Parent does not expect adult-like support from child	0.70	0.68	2.00	-1.00	8.27	<.01
Total of items 1-7	7.53	5.03	18.00	0	11.97	<.001

comparisons, significantly ($p<.05$) on six of the ten. These areas of significantly greater change for females were: awareness of own needs, awareness of child's needs, ability to translate self- awareness into behavior change, use of support systems, initiating activities and the total score.

It was difficult to get men to accept treatment, even though they had more severe problems, and even when they were treated they did not make as much progress as females did.

Age of Parent. Parents were divided into four age groups; 18-25, 25-30, 30-35 and 35-40 year olds. At the beginning of treatment, there were significant differences as a function of age on six of the ten scales. The 35-40 year olds clearly were the least adjusted group. On a few scales the 18-25 had adjustment difficulties to match the 35-40 year olds, with the 25-30 and 30-35 year olds doing the best of the groups.

When treatment gains were assessed, the residualized gains showed that the youngest and oldest groups showed less change on all ten scales than did the middle range of ages. These differences were significant for the items having awareness of own needs, having impulse control/assertiveness achievement, initiating relationships, initiating activities and total score with the oldest age group of parents (35-40) improving significantly less with treatment than all other groups.

Abuse Index and Abuser Status. Adults who had children who were in the severe, moderate or sexual abuse group; or the mild, failure to thrive group or the potential abuse group did not differ significantly on adjustment at the beginning of treatment. Nor were there any significant differences in the change scores between the groups at the end of treatment as a function of Severity of Abuse Index of the child.

The adults themselves were classified into three groups: spouse of abuser (n=13), actual abuser (n=11) and potential abuser (n=11). There were no significant differences between these three groups at the beginning of treatment, or when comparing gains.

Thus, the finding that potentially abused children did not differ from their actually abused peers in adjustment was duplicated in their parents' data, where actual abusers did not differ in adjustment from potential abusers.

Length of Time on Caseload. For this analysis, adults were grouped into five groups depending on how long they were treated. There were no significant differences in the groups prior to treatment. There were two significant ($p=.05$ or less) differences on the Adult Client Improvement item change score. The longer the time in treatment, the more improvement in impulse control/assertiveness (Item 5), and the more the client improved in translating awareness into behavior change (Item 4). However, the general trend for all the items and the total was that the longer a client stayed on the caseload, the more the client improved.

Summary of Adult Client Adjustment at Beginning of Treatment and Improvement Ratings After Treatment

As hypothesized, there were significant differences at the beginning of treatment between males and females, with females having better adjustment. The significant differences in age of parent did show that the oldest group had the most severe problems, but the very youngest group was next in order of poor adjustment, with the 25-35 year olds having better ratings at intake than the youngest or oldest groups. The adjustment of the actual, potential and non abusers did not differ prior to treatment, and this was contrary to the hypothesis that actual abusers would have poorer adjustment.

The most notable finding of the improvement analyses was that the Family Center social workers rated their clients as generally improved in the areas measured by the Adult Client Improvement Form. There were indications that as hypothesized, the women in the sample showed more improvement than did the men, that parents over 35 showed the least improvement, and that amount of improvement in some cases was positively related to the length of time the client spent in treatment. Contrary to expectation, there were no differences between groups with different abuse statuses.

The Parent/Child Interaction Form (PCI)

The Family Center social workers completed sixty-four Parent/Child Interaction forms for the clients on their caseload. Each form represents one interaction between a parent and a child. Thus, a particular child might be included in two Parent/Child Interaction scales, one for each parent. Conversely, a parent might be included in more than one Parent/Child Interaction if the parent had more than one child. Each interaction was rated twice, once to indicate the beginning of treatment interactions and one to indicate the end of treatment interactions. Each item was weighted according to the social worker's judgment about it's relative importance to the total interaction. Pre scores were subtracted from post scores to obtain difference scores on each of the seven Parent/Child Interaction change score. Gains were residualized for between group comparisons. At the beginning of treatment the average Parent/Child Interaction score was 9.3 (a score of 8 indicates "minimal progress") and at the end the score was 16.8 (a score of 16 indicates "fair progress").

As was found with both the CI and the ACI, the social workers believed that the sixty-four interactions as a group were significantly improved (change score significantly greater than zero). This data is presented in Table 13.

For the Parent/Child Interaction it was possible to group the interactions in a variety of ways to investigate the possibility of differential improvement. First, the interactions were grouped according to selected parent characteristics and then according to selected child characteristics. The results of these analyses are presented below.

Sex of Parent. If children's interactions with parents were compared before treatment of the parents, the interactions with their mother were always better than with the father, and they were significantly better with the mother for every item and the total, except the item "parent does not look to child for adultlike support."

There were no significant differences in interaction improvement between the child's interactions with male parents (n=20) and the child's interactions with female parents (n=28). What small differences there were, favored the child-mother interactions in all eight comparisons.

Thus, the father was doing worse at the beginning and end of treatment with his child(ren) than was the mother.

Age of Parents. The oldest group of parents (age 35-40) had consistently poorer interactions with their children then did any other age group, but only once did the difference reach significance, on Item 6, "parent/child interactio relates to child's needs."

However, when change scores were examined, the youngest group of parents (18-25) changed the least, next the oldest (35-40), next the 25-30 year olds. The 30-35 year olds were significantly the most improved on the items; stopping of abuse, relating to child's needs, not looking for adultlike support from the child, and the total score.

Abuse Index and Abuser Status. Parents did not differ on their interaction scores before treatment based on the severity of abuse status of their child. Nor did they differ on the amount of gain through treatment based on the Severity of Abuse Index.

However, there were large differences in the interaction scores before treatment, based on abuser status of the parents. Table 14 summarizes these differences.

TABLE 14

INTERACTION SCORES BEFORE TREATMENT

	Not Abuser (n=17)	Actual Abuser (n=13)	Potential Abuser (n=18)	F prob.
1. Physical abuse/potential abuse stopped	3.76	1.08	1.89	$p<.000$
2. Parent listens to child	1.65	.54	1.17	$p<.003$
3. Parent reaches out in positive way to child	1.41	.54	1.28	$p<.05$
4. Child reaches out to parent in positive way	1.59	1.08	1.56	N.S
5. Parent and child reach out to each other	1.71	.77	1.44	$p<.03$
6. PCI relates to child's needs	1.24	.46	1.06	$p<.01$
7. Parent does not look to child for adultlike support	.94	.77	1.05	N.S
Total of Items 1-7	12.29	5.23	9.44	$p<.004$

With few exceptions, actual abusers had the worst interactions with their child at the beginning of treatment, and potential abuser's interactions with their child were worse than, but not significantly different from, the non abusive spouse.

There were no differences between the groups as a function of gains made in treatment.

Length of Time on Caseload - Parents. Interactions were divided into 4 groups on the basis of how long the parents spent in treatment. Group 1 (n=6) was on the caseload less than six months, group 2 (n=8) was on the caseload between 6 and 12 months, group 3 (n=16) was on the caseload between 12 and 18 months, and group 4 (n=18) was on the caseload between 19 and 24 months. The general trend was for the parents who were in treatment the shortest and longest times to have worse interactions with their children before treatment, and this difference reached significance on one item "parent/child interaction relates to child's needs." There were no significant differences on the change scores with different lengths of treatment.

Sex of Child. There were no differences in interaction ratings between boys and girls at the beginning of project involvement. Interactions between male and female children and their parents were compared using t-tests. In each comparison, girls' (n=7) interactions with both their mother and father improved more than the boys' (n=28) interactions did. This difference reached statistical significance only once, but the direction of the differences never varied.

Treatment versus No Direct Treatment at Intake. Some children on the Family Center caseload received direct treatment beginning at intake; others did not, but their parents received treatment. Of the children on whom Parent/Child Interactions were completed, 19 did not receive direct treatment beginning at intake while 16 did. At intake, those who were assigned to direct treatment had significantly worse interactions with their mothers on the items, parent listens to child; parent reaches out in a positive way; child reaches out in a positive way; and, parent and child reach out to each other. There were no differences in gains in mother interaction between the two groups. Interactions with fathers did not differ significantly at the beginning or end of treatment for the two groups.

Length of Time on Case. The children were divided into five groups, depending on the length of time they spent on the Family Center caseload. At the time of Intake, children who remained on the caseload longest differed from all other groups in that they had consistently worse interactions with their mothers, and this reached significance for the items, parent listens to child; parent reaches out to child in positive way; and parent and child reach out to each other. At the end of treatment, the children on the caseload the shortest time (0-6 months) made consistently less progress in relating to their father than did the other groups. This difference reached significance only on the item "child reaches out to parent in a positive way." There were no differences in gains made in interacting with mother as a function of length of time in treatment.

Severity of Abuse. The interactions could be divided into groups on the basis of the severity of abuse which brought the clients to the attention of the Family Center. Ten interaction ratings were between severely, moderately, or sexually abused children and their mothers, five between these children and their fathers. Five interactions were between mildly or emotionally abused children and failure to thrive children with their mothers, four between these children with their fathers. Twenty were between potentially abused children

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and their mothers, 12 between these children and their fathers. At the beginning of treatment, the mild-emotional-failure to thrive group had consistently worse interactions with their fathers than did the other two groups which did not differ from each other. The differences reached significance on the item, "parent listens to child" and the total score. There were no differences when interactions with the mother were examined. There were no significant differences on the Parent/Child Interaction change scores or total change scores between the three different abuse groups with either the mother or father. What small differences there were tended to favor the mild-emotional-failure to thrive group improving more than the other two with both mother and father.

Age of Child. Two age groups were formed. Interacting with their mother were 22 children, 0-8 years old; and 14 children, 9 or older. Interacting with their father were 14 children, 0-8 years old; and 6 children, 9 or older. The younger children consistently had better interaction scores with both parents at intake. These differences reached significance on "child reaches out to parent in a positive way" and "parent reaches out to child in a positive way" for the children's interactions with both mother and father. In addition, the younger children had significantly higher ratings at intake on "parent and child reach out to each other positively" and "parent/child interaction relates to child's needs," where relating to their father was rated.

Thus, younger project children had better interaction scores at intake with both their parents. There were no significant differences between the groups as far as the progress made in interacting with parents by the end of the family's involvement with the project was concerned. Younger and older children improved their interactions with parents equally.

Summary of Parent/Child Interactions before Intervention and Improvement with Intervention. As hypothesized, children's interactions with their mothers were significantly better than their interactions with their fathers at the beginning and end of treatment. Interactions with mothers improved more than interactions with fathers did. As expected, the oldest parents had the most severe problems in interacting at the beginning of treatment, but even when the gains were residualized, the oldest parents made the most gains with treatment. The youngest parents were the hardest to reach in terms of producing more effective interactions with their children after treatment. This was unexpected, and shows that more attention to finding effective interventions for parents 18-25 is needed.

As expected, parents who were actual abusers had more severe interaction problems with their children than potential abusers and the nonabusing spouses did. However, the potential abusers and nonabusing spouses did not differ, showing that both groups needed intervention. All groups gained equally with treatment.

Length of treatment of parents was related in an unexpected way to parent/child interaction problems. Those parents on the caseload the shortest and longest times had the more severe interaction problems. The parents who were on the caseload the shortest time may include some who terminated prematurely and thus were unmotivated. Those in treatment the longest time may include "hard core" cases. There were no significant differences in interaction improvement made by length of time on caseload. Sex of the children was not related to interaction problems at the beginning of treatment, and thus contradicted the expectation that boys would show more interaction problems than girls. Girls consistently improved more than boys did with project involvement.

The children selected to receive direct treatment had more severe interaction problems with their mothers than did children whose parents alone received treatment. Treatment children did not improve in parent/child interactions to any greater degree than did children not receiving direct treatment, contradicting the hypothesis involving greater gains for children who received direct treatment.

The children who remained longest on the caseload had worse interactions with their mother to begin with than did the other groups, and all groups gained equally through the project intervention as far as mother interactions were concerned. However, the groups on the caseload the shortest time made the least progress in improving their relationship with their fathers.

The children who were severely abused did not differ from the potentially abused children as far as interaction ratings at the beginning and end of treatment were concerned. The mildly or emotionally abused group had more difficulties interacting with their fathers than did the severely abused groups. All groups gained equally during the project's involvement. Once again, the potentially abused children did not differ from the actually abused children.

As expected, younger children had better interactions with both their parents than older children did at the beginning of treatment. Both younger and older children gained equally through project intervention.

Discussion of Client Rating Forms Analysis

These three forms, the CI, ACI, and PCI were designed to allow the Family Center social workers an opportunity to comment on the changes they saw in their clients. This was considered to be important information since they would be able to use all the data available to them as trained observers, regardless of whether it was formally collected research data or not. These ratings were overwhelmingly positive. It is certainly satisfying to see positive changes in a group of abusing or potentially abusing clients. It is important to consider, however, that in a very real sense, the social workers were rating themselves and their work when they rated their clients. This situation maximizes the possibility of rater bias. The fact that the workers did not often differentially rate groups of clients who might be expected to fare differently suggests that at least some of the positive change noted might be a function of rater bias.

In addition, even though the changes were significantly different from zero change for parents, children and the interaction between parents and their children, it must be noted that the gains were modest. The average change for parents and parent/child interaction only brought the mean rating up to "fair progress," and the children were not even up to the "fair progress" level at the end of project involvement. Many writers (e.g., Steele, Court, Helfer) in the area of child abuse have said that abuse workers must be satisfied with modest gains because these clients are extremely difficult to treat. However, the gains made by the project children were not at the modest level. More effective intervention strategies for children are needed.

Outcome Analyses of Self-Esteem Scales, TS, SD, CIP, and CACL

As reported in the last two sections, the Family Center social workers rated the clients on their caseload as having significantly improved between the beginning and end of the project on a variety of dimensions. With the behavioral data collected on the TS, SD, CIP, CACL, and the Self-Esteem Questionnaire, there was the opportunity to further investigate the nature of this improvement. It was hoped that specific behavioral changes could be

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identified which might serve as an explanation for the social worker's ratings.

To accomplish this end, change scores were calculated for each of the clusters of the TS, SD, CIP, and CACL. Change scores were also calculated between test and retest Self-Esteem Questionnaire scores for those children who were retested. Since the number of administrations of each of the other forms could (and did) vary between children, the following strategy was used to compute pre- to post-changes. For the SD, CIP, and CACL, a child's first and last administration were chosen as pre- and post-measures, respectively. The telephone survey was different from these other forms since it specified that only the twenty-four hours prior to completing the form were to be considered by the respondent. It was felt that this condition might introduce spurious variability into pre/post change scores if only the first and last forms were considered. Therefore, in an effort to increase the stability of the pre- and post-scores, the first two TS's were averaged and considered a pre-measure, and the last two were averaged and considered a post-measure. For those children who had less than four TS's completed on them, this averaging procedure was not completed.

Change scores were calculated by simple subtraction. The direction of subtraction (i.e., pre/post or post/pre) was selected to always make a larger positive change score indicate face valid improvement. The direction of subtraction for each factor is shown in Table 15.

Self-Esteem Scores

Eight children in the treatment caseload had retests on self-esteem after treatment. The change in self-esteem was in the positive direction, as was predicted. However, the self-esteem score was not significantly

TABLE 15

DIRECTION OF CHANGE SCORE CALCULATIONS FOR THE TS, SD, CIP, CACL

Test	Cluster	Direction of change score Calculations	Meaning of Positive change
TS	1) Shy	Post-pre	Less shy behavior
	2) Acting out	Post-pre	Less acting out
	3) Passive aggresive	Post pre	Less passive aggressive
	4) Role reversal	Post pre	Less role reversal behavior
	5) Seeking interaction	Post-pre	Decrease seeking behavior
	6) Poor peer relation	Post-pre	Decrease poor peer relations
CIP	1) Good interaction	Post-pre	More good interaction
	2) Provoking child	Pre-post	Less provoking
	3) Abusive interaction	Pre-post	Less abusive interaction
SD	1) Warm	Pre-post	More warm
	2) Acting out	Post-pre	Less acting out
	3) Active	Pre-post	More alert
	4) Poor concentration	Post-pre	Better concentration
CACL	1) Positive	Post-pre	More positive
	2) Upset	Pre-post	Less upset
	3) Scared	Pre-post	Less scared
	4) Active	Pre-post	Less acting out

higher after treatment. However, this may be because the children's self-esteem was not really low at the beginning. A more informative way to view the data is to note that five of the eight children tested could have moved from Low to Medium or High, or Medium to High in the classification system, as they were not already in the high group at the beginning. All of these five children did change towards a more positive image, moving up at least one classification. This finding is in contrast to the adult results where only half of those who could change positively did so. In fact, two adults changed towards more negative self-esteem scores. A conclusion can include that treatment of children produced a more consistent, positive change in self-esteem than did the treatment of adults.

It would be extremely interesting to retest these children as they grow to see if the self-esteem gains remain after termination of treatment.

Behavioral Rating Forms

Change scores were obtained for 80 children on the TS, 79 children on the SD, 69 child-parent pairs on the CIP, and 35 children on the CACL. Analysis of these change scores revealed that, for the children as a total group, none of the six TS clusters, none of the four SD clusters, and none of the four CACL clusters had mean change scores significantly different from zero. Only one of the three CIP clusters (provoking child) had mean change score significantly ($p=.05$) different from zero, and this was in the negative direction.

These findings were in sharp contrast to the social worker's ratings of improvement in their caseload children discussed previously. There are several possible explanations for this difference. First and foremost, the behavioral ratings mentioned above include many more children than were rated by the social workers. It could be that these two groups of children (i.e., caseload versus non-caseload children) were quite different in the amount and direction they changed. Secondly, there may be different, identifiable subgroups of children, some of whom changed in one direction and some of whom changed in the opposite direction. By including these children in the same analysis, the effect might have been mutual cancellation of change scores. This would account for the essentially zero change score means.

A third and obvious explanation would be that these zero change scores reflect the fact that, on the whole, no change occurred in these areas. This would indicate that the improvement which the social workers noted was not due to changes in the behavioral areas which were assessed on these forms. A fourth explanation is that changes did occur in these behavioral areas but that these forms were not sensitive enough to pick them up.

Some of these explanations are more likely to be true than others. Experience gathered from the use of these forms in the monthly feedback sessions with the social workers indicated that the forms were both accurate and sensitive to change. Statements made about a client on the basis of information gathered from these forms were often agreed with enthusiastically by the social workers who were familiar with the case. This experience would argue against the fourth explanation.

The third explanation also seems unlikely. The social workers had a great deal of input during the form development phase to insure that the forms could be used to measure important and meaningful behavioral changes. There were opportunities during the course of the project for the social workers to give their opinions about the relevance and importance of the data being collected on these forms, and those opinions were invariably positive.

The first and second explanations could be investigated empirically by further analysis of the data. This further analysis is presented below.

Comparison of Subgroups on the Behavioral Change Scores

Since the Family Center caseload children were the only ones to receive social worker ratings of improvement, an analysis was done to compare the behavioral changes of caseload versus Crisis Nursery only children. The caseload children were either receiving direct treatment or their parents were receiving treatment. These comparisons yielded several significant differences between the groups which mostly favored the caseload children. The caseload children improved more than the Crisis Nursery children on the acting out cluster of the TS ($p \leq .05$), on the provoking child cluster of the CIP ($p \leq .01$), on the acting out cluster of the SD ($p \leq .05$) and on the poor concentration cluster of the SD ($p \leq .05$). The Crisis Nursery children became more active, as measured on the active cluster of the SD ($p \leq .05$) than did the caseload children. There were no significant differences between the two groups on any of the CACL clusters. All of this data is presented in Table 16.

These findings showed that there were some differences between the amount of behavioral improvement shown by caseload and Crisis Nursery children. These improvements were in areas of crucial importance to the children. A less provoking, less acting out child with better concentration is bound to do better in school, both academically and emotionally. To the extent that such a child is generally easier to live with, his parents may interact better with him and reinforce him more. These were the types of behavior changes it was most hoped that the children would acquire over the course of the project. Both desirable behavior change and self esteem changes occurred in the caseload children. The greater improvement of these children when compared to Crisis Nursery children

TABLE 16

COMPARISONS OF CASELOAD VERSUS CRISIS NURSERY CHILDREN ON BEHAVORIAL CHANGE SCORES

Test	Cluster	Caseload x	Crisis Nursery	T Valve	P	Caseload N	Non-Caseload N
TS	Shy	-.08	.03	1.26	ns	32	47
TS	Act Out	.12	-.02	-2.26			46
TS	Passive Aggressive	-.05	.04	1.32	ns	32	47
TS	Role Reversal	-.02	-.02	0.04	ns	32	47
TS	Seek Interaction	-.09	.01	1.41	ns	32	47
TS	Poor Peer Relations	.06	-.08	-1.80	ns	32	47
CIP	Good Interaction	.00	.14	0.58	ns	27	41
CIP	Provoking Child	.18	-.51	-3.24	.002	27	41
CIP	Abusive Interaction	.07	-.07	-.91	ns	27	41
SD	Warm	.01	.26	.89	ns	32	45
SD	Acting Out	.08	-.50	-2.11	.04	32	45
SD	Active	-.27	.30	2.18	.04	32	45
SD	Poor Concentration	.40	-.41	-2.34	.02	32	45
CACL	Positive	-1.89	-0.89	0.57	ns	12	21
CACL	Upset	-2.54	1.66	1.61	ns	12	21
CACL	Scared	-0.40	0.52	0.37	ns	12	21
CACL	Active	1.19	0.23	-0.63	ns	12	21

may just be that the short term intervention given the Crisis Nursery children involved insufficient time to produce desired changes.

To investigate whether it was possible to identify subgroups of children whose changes were in opposite directions, an analysis similar to the one performed on the social worker's client rating scales was performed.

Differences in behavioral change scores were examined for a variety of subgroups. The population of children was subdivided by their behavioral profile at intake (O-TYPES), by their sex and age, by the length of time they spent on the Family Center caseload. The findings are presented below.

O-TYPE Analysis

The O-TYPES analysis yielded several significant and interesting differences. On the CIP, the group of children who were characterized as "withdrawn" at intake became more provoking and increased in abusive interactions with their parents by the end of the project. These changes were not only in relation to where they started at intake, but also were significant (provoking child) or nearly significant (abusive interaction P=.06) when compared to the other O-TYPED children. On the CACL, the children who were characterized as Acting out at intake show an "increase" on the "upset" and "scared" clusters at the end of their project participation. They also showed more of an increase on the behaviors in the Role Reversal cluster of the Telephone survey than did the other O-TYPED children.

These findings are interesting because each of these changes might be considered "improvement" for these children, given where they started at intake. For a withdrawn child, an increase in acting out behavior could be seen as progress in the eyes of a social worker. Similarly, for an acting out child, an increased score on the upset and scared dimensions of the CACL might be seen as increasing awareness of his dangerous and precarious position in an abusive household. This demonstrates how different groups of children can all be seen as improved by a social worker, yet have an averaged behavioral change score around zero. This tends to support the second explanation offered above to account for the zero change scores; namely that, in essence, the withdrawn children became more active and the acting out children became less active, thus cancelling each other out in analyses, which depend for their significance upon differences between average scores. The results of these O-TYPE analyses are summarized in Table 17.

Other Analyses

The other analyses (i.e., sex, age, direct treatment vs. no direct treatment, and length of time on Family Center caseload) did not reveal any consistent or meaningful differences in behavioral change scores between the different subgroups of O-TYPED children.

Discussion of Behavioral Change Score Analyses

In retrospect, it can be seen that the design of this portion of the outcome analyses was based on two unarticulated assumptions. First, it was assumed that it would be possible to identify "positive" and "negative" classes of behavior without regard to the specific context in which these behaviors occurred. Secondly, it was assumed that client improvement could be measured behaviorally by tracking the increase in "positive" or the decrease in "negative" behaviors over time. Now, with all the advantages that hindsight confers, it is possible to see the weaknesses of these assumptions.

TABLE 17

COMPARISON OF BEHAVIOR CHANGE SCORES BETWEEN O TYPE GROUPS

Test	Cluster	O Type Acting Out Mean	O Type With-drawn Mean	O Type Outgoing Mean	O Type Upset Abused Mean	F Ratio	F Prob.
CIP	1) Good Interaction	.3967	.1821	-.2329	-.0800	.518	NS
	2) Provoking Child	-.2333	-1.0286	.0186	.4667	4.103	.016
	3) Abusive Interaction	.1217	-.4150	-.1243	.4433	2.789	NS
SD	1) Warm	.0200	.3907	-.7971	-.1775	1.510	NS
	2) Acting Out	-.3900	-.4033	-1.2257	-.3225	1.116	NS
	3) Active	.0357	-.0667	-.200	-.4500	.161	NS
	4) Poor Concentration	-.4757	-.5560	-.1886	.4200	.446	NS
CACL	1) Positive	.4714	-.6923	-2.0714	-2.1250	.324	NS
	2) Upset	-6.4700	1.8723	-1.5314	4.4450	3.451	.030
	3) Scared	-4.3586	-.6308	-1.4757	7.5350	4.231	.014
	4) Active	.9643	1.4615	.6671	0	.168	NS
TS	1) Shy	-.1660	-.0094	.0229	-.0825	1.544	NS
	2) Acting Out	-.0800	.0313	.0571	-.0750	.422	NS
	3) Passive Aggressive	-.0680	-.0156	.0729	.0950	1.438	NS
	4) Role Reversal	-.1280	-.0550	.1443	.3750	10.098	.001
	5) Seeking Interaction	.1340	-.0513	-.0471	-.0425	.846	NS
	6) Poor Peer Relations	.0000	.0081	.0514	-.2525	.833	NS

There does not seem to be any behaviors which are necessarily positive or negative in the abstract. Positive-ness or negative-ness is the judgement of an observer and not an attribute inherent to the specific behavior. This evaluative judgement can only be made in specific cases and not generally. Two people can change in opposite ways and both of them can be judged to have improved. The O-TYPE's analyses and the social worker's case ratings show how this might be the case. There is no straightforward or necessary connection between any specific behavioral change and the evaluative judgement made about that change.

These new and more detailed assumptions suggest that more attention should be paid to the social worker's ratings and the O-TYPE when analyzing improvement ratings. The social workers had the opportunity to inspect and understand the research data as well as having a variety of other types of data at their disposal. Their task was to move from this data to an evaluative judgement about a particular client's improvement. They were able to come to such a judgement in each case based on the data and the meaning it assumed in a specific context. The O-TYPE analysis was an attempt to approximate this procedure to some degree. In the O-TYPE analysis,each change score could be interpreted within the context of what sorts of behaviors that group of children exhibited at the time if intake. Evaluative judgments could then be made about whether that change in that context might be considered an improvement.

Given these new assumptions, it seems that this series of outcome analyses can be understood as follows: Both child and adult clients, on the whole, improved during the project. Each client changed in different ways consistent with the ways the client needed to change, given his/her particular situation at the time of intake. These changes were observed and judgments were made by the treatment staff as to the desirability of the change. These judgments showed no consistent or general relationships to the behavioral change data, once it was taken out of the total context. It is possible to predict which way the child should change, if he is going to show improvement, based on his/her behavior patterns at the beginning of treatment. The reason the social workers only rated the children as achieving minimal to fair progress became more clear on the basis of the behavioral analysis. The withdrawn children became more acting out and the upset children more frightened; and, while such changes indicated progress, these were not optimal progress changes. Obviously, many of the children were not ready to be terminated when the project was completed.

The Marital Questionnaire

The Marital Questionnaire is based on a questionnaire designed by Bergner. It was modified to be more applicable and understandable to the population served in this study. See Appendix IV for a copy of the questionnaire. It was administered at the beginning, three months, one year, and/or at termination to each husband and wife in each treatment couple.

Table 18 presents the items contained in each of the five clusters constructed from the questionnaire on the basis of inspection of item correlations. There were not enough completed questionnaires to get a factor analytic solution.

During the lifetime of the project, the questionnaire was used to provide information to the social workers. Answers of husbands and wives were compared and disagreements around items and areas were noted. At first, a report on the questionnaire responses was written by the psychologist, so that the worker could discuss results with the couple. After several months, the workers felt comfortable noting discrepancies and dissatisfactions

TABLE 18

CLUSTER STRUCTURE FOR THE MARITAL ADJUSTMENT QUESTIONAIRE

Cluster #	Cluster Name	Item #	Item
1	Communication	1.	Satisfied with amount of leisure time spent with spouse.
		-2.	Affected by what affects spouse
		4.	Aware of spouses mood
		5.	Spouse aware of your mood
		7.	Spouse follows through with responsibilities
		8.	Self disclosure with spouse
		9.	Does spouse understand self disclosure
		10.	Share day with spouse
		11.	Spouse share day with you
		12.	Expression of positive feeling toward spouse
		13.	Spouse expresses positive feeling toward you
		-15.	Spouse wants to spend more time with you than friends
		17.	Count on spouse for comfort
		18.	Satisfied with sex life
		19.	Spouse counts on you for comfort
		21.	You and spouse have good time together
		25.	Feel close to spouse
		-26.	Have something to say to each other
		31.	Take spouse's opinion into consideration when deciding
		32.	You and spouse enjoy the same activities
		-44.	Live your lives together
		46.	Talk to spouse
2	Respect	23.	Spouse decent person, worthy of respect
		30.	Spouse basically a good person
		33.	Spouse a good husband/wife
		34.	Spouse a good mother/father
		-35.	Someone else would make you happier
3	Poor Relationship	14.	You want to spend more time with friends than spouse
		22.	Others more important than spouse
		24.	Prefer others' company to spouse's

continued...

TABLE 18 (continued)
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Cluster #	Cluster Name	Item #	Item
3 (con'd)	Poor Relationship	-37.	Spouse couldn't take care of house/children
		-38.	Spouse couldn't take care of himself
		39.	Feel alone even when spouse is there
		42.	Spouse often unpleasant and disagreeable
		43.	Children, friends, parents or job are more important than spouse
4	Expectations	47.	Couple is open and honest
		48.	Partners close and loving
		49.	Partners share interest
		50	Think of spouse before self
		51.	Spend leisure time together
		52.	There for each other
		53.	Share intimate thoughts and possessions
5	Tolerance for Independence of Spouse	54.	Partners feel angry at each other
		55.	Partners find someone else attractive
		56.	Couple disagrees over something
		57.	Wants to be away from spouse-short time
		58	Partner prefers to spend time with someone else
		59.	Partner involved in activities without spouse
		60.	Partner does not share thoughts

Cluster 2. Respect for Spouse. The second cluster assessed whether the person thought the spouse was a good, decent person, was worthy of respect, was a good mother or father and thought no one else would make him/her any happier.

Over sixty percent of the husbands and wives answered "always" to all the questions in this cluster. No one had a score on the negative side (infrequently or never respect your spouse) of the cluster. Sixty-one percent of the wives had less respect and good feelings about their husbands than their husbands had for them, in 23% of the couples there was no difference between the couple's ratings, and only 16% of the husbands had less respect and good feelings for their wives than the wives did for them.

After treatment, 33% showed no change, 28% became more negative and 39% became more positive. Again, the change score was not different from zero, because almost as many spouses lost respect as gained it. Treatment probably increased awareness of a person's true feelings about his/her spouse.

There were no significant differences at the beginning or end of treatment on the marital disruption scoring based on this factor, for severity of abuse index of child, abuser status, or treatment given. As in the previous cluster, there were greater disruption scores at the beginning and end of treatment in the homes of the mild-emotionally abused children, although, again, these were not signicantly greater.

Cluster 3. Poor Relationship. This is a closeness type of cluster, which contains items related to the importance of the spouse relative to other people in the person's life, and how gratifying living with the spouse is for the person.

themselves, and then discussing the results with their clients.

An example of a report follows:

> This is a couple whose philosophies on closeness differ. The husband seems satisfied with a lot less closeness than the wife is (see ratings under what makes a good marriage, 59). He feels that other things are more important than his spouse frequently (43) and she doesn't. She feels a separation from him emotionally (44, 45, 46) and that she can't count on him for comfort (17) although he can count on her (19). She thinks that someone else may meet her needs for closeness better than he does and often prefers the company of other men.
>
> They both have dissatisfactions and resentments--he in the area of her sexual availability and she in the area of his lack of help around the household.
>
> She seems to feel more negative to him than he does to her--saying he's less of a good person (30) and he's more disagreeable (42) than he sees her as being. This is reflected in her lower marriage satisfaction rating (somewhat unsatisfied) and his rating of fairly satisfied.
>
> In general, the main problem seems to be lack of communication about wants, needs, and feelings. They both feel a lack of understanding and she senses his greater unwillingness to talk and open up. Anger seems the easiest feeling to communicate.

In looking at the data, it was decided that the difference between the husband's and wife's scores on the various factors would be an index of strife in the marriage. If both were very satisfied the problems might be minimal. If both were very dissatisfied, they would probably be working to terminate the marriage. Primary marital disruption was hypothesized to occur when viewpoints differ, when pressure to change would be generated by the disagreement.

Cluster 1. Communication. The first Marital Questionnaire factor assesses the amount, type and style of communication between husband and wife. At the beginning of treatment, half of the 48 husbands and wives said they were satisfied all of the time or somewhat frequently with this aspect of their marriage, while only two said they were never satisfied. Sixty-nine percent of the wives were more dissatisfied with their communications within the marriage than were their husbands.

After treatment, 37% became more negative about their communication, and, since much of the early positivity was no doubt denial, this probably represents a more realistic perception of their marriage. Since some of the negative changes were very large, the mean change after treatment is not different from 0 change, even though 63% of the husbands and wives became more positive. After treatment, 62.5% of the wives were more dissatisfied with their marital communications than were their husbands.

There was no significant difference in the marital disruption scoring (husband-wife difference score) at the beginning of treatment for the couple based on whether the wife or husband was an actual or potential abuser. There were also no significant differences as a function of whether the child in the home was severely, moderately or sexually abused, mildly or emotionally abused or failure to thrive; or potentially abused. However, there is a larger disruption in the homes of the mildly emotionally was abused, failure to thrive group. There were no significant differences at the end of the treatment either, although the mild-emotionally abused group of children continued to live in the most maritally disruptive environments, where communication satisfaction was concerned.

Communication differences were not a significant factor in what type of treatment the wife received, but the husbands who had very large differences in the communication satisifaction from their wives, in the direction of more dissatisfaction, were significantly more often assigned to individual therapy rather than marital, family or child management group therapy.

Before treatment, only two people said "frequently or always" to all the items in the Poor Relationship cluster. Seventy-seven percent had an average score on the cluster indicating that they infrequently or never felt they had a poor relationship, as defined by this cluster. Forty-seven percent of the wives had higher scores on the poor relationship cluster than their husbands did. In 15% of the couples, there was no difference; and in 38% of the couples, the husband thought their relationship was poorer than the wife judged it to be.

After treatment, 50% judged their relationship as less poor than it was before treatment, 28% made no change, and 17% judged it as worse at the end. The changes on this cluster were not large and were not significantly different from zero change. After treatment 62% of the wives thought their relationship was poorer than their husbands did and only 25% of the husbands thought their relationship was poorer than their wives did.

Although, once again, their were larger disruption scores on this cluster in the homes of the mild-emotionally abused children at the beginning of treatment, the differences based on severity of abuse index were not significant, and they were not present after treatment. There were no significant differences in disruption scores based on abuser status and assignment to treatment.

Cluster 4. Expectations. This cluster explored expectations for how often things should occur in a really good marriage. Expectations about openness, closeness, shared interests, and selflessness are described in the items.

Scores were classified: High expectations (7-9 points), Moderately High (10-13 points), Moderate (14-16 points), Moderately low (19-23 points), and Low (21 points or more). At the beginning of treatment, none of the husbands or wives had low expectations about what would make a good marriage. Twenty-four percent had high expectations, 39% had moderately high expectations, 31% had moderate expectations, 6% had moderately low.

After treatment, expectations for marriage in general increased. Seventy-one percent of the Family Center clients increased their expectations, 23% had their expectations remain the same, and 6% decreased their expectations.

Differences in expectations between husband and wives would be a particularly difficult area in a marriage, because disappointment and frustration would surely occur in a marriage where expectations for what should happen were different. At the beginning of treatment, in 38% of the couples there were no differences in expectations, in 46% of the couples, the wives' expectation scores exceeded the husbands', and in 38% the husband's expectations exceeded the wife's.

This difference between the wives' and husbands' expectations is interesting. Not only do the wives have consistently higher expectations for openness, closeness, sharing and selflessness in a marriage, but they see their relationship as having less communication, their spouses as less good, and their relationship as poorer than do their husbands. This negative view of their marriage coupled with their high expectations would lead to much more frustration and unhappiness in their marriage than would a situation where they were unhappy, but didn't expect much anyway.

The disruption scores were related in an interesting way to treatment assignments. Couples with the highest discrepancy between husband and wife expectation scores at the beginning of treatment were assigned to marital therapy. This is a sensible basis for offering a couple marital treatment. By the end of treatment, the couples who had had marital treatment did not differ from those having other treatments. Marital treatment thus seems to have brought husband's and wive's expectations closer together.

Cluster 5. Tolerance for Independence of Spouse. This cluster assesses the type of problems or actions which could occur and have the person still think it is a good marriage. Mostly, the actions are of the type which lead to independence of the spouse. Scores were classified as: High tolerance for independence (14 or less points), Moderately high tolerance (15 through 17 points), Moderate (18 through 20 points), Moderately low (21 through 23 points), and Low (24 points and up). In general, this group was not very tolerant of independent actions on the part of their spouse. There were no high tolerant persons, 15% moderately high, 41% moderate, 31% moderately low, and 13% low tolerance for independence. At the beginning of treatment, 54% of the wives were less tolerant of independence than were their husbands, 16% were equal in tolerance, and 30% of the husbands were less tolerant than their wives.

After treatment, 38% of the wives had less tolerance for independence of spouse than their husbands, 47% had equal tolerance, and 25% of the husbands had less tolerance than their wives.

This was a favorable outcome of treatment, as marriages where tolerance for independence is very different are bound to have difficulties. If the more tolerant spouse tries to assert his/her independence, there will be very little understanding of and response to the less tolerant spouse's distress at that time. Mutual agreement on how much independence is desirable in a good marriage leads to better understanding of each other's feelings.

Overall Marital Satisfaction Rating. The Family Center project clients were asked to rate their overall marital satisfaction at the beginning and end of treatment from 1--Completely unsatisfied to 9--completely satisfied.

The distribution of scores at the beginning of treatment was as follows:

1.	Completely unsatisfied	0%
2.	Very unsatisfied	5%
3.	Fairly unsatisfied	2.5%
4.	Somewhat unsatisfied	15%
5.	Neither satisfied nor unsatisfied	10%
6.	Somewhat satisfied	12.5%
7.	Fairly satisfied	20%
8.	Very satisfied	30%
9.	Completely satisfied	5%

Over 50% were fairly satisfied or better. At the beginning of treatment, 23% of wives were more satisfied than their husbands, 31% of spouses had equal satisfaction and 46% of husbands were more satisfied than were their wives. After treatment, there were no wives more satisfied than their husbands, 50% of couples had equal satisfaction and 50% of husbands were more satisfied than their wives.

Thus, the overall ratings corroborate the findings from the individual clusters. Wives in the project marriages were generally more unhappy and less satisfied with their marriages than were husbands, both at the beginning and end of treatment. The satisfaction of the wives improved somewhat with treatment, but the husbands were still, for the most part, the happier of the two partners.

As a group after treatment, 23% became more satisfied with their marriages, 54% stayed the same and 23% became less satisfied. On the overall rating, as on most of the cluster scores, about as many increased in satisfaction as decreased. Rather than the cases which decreased in satisfaction being treatment failures, it is just as likely that the mechanism of denial was changed by treatment, so that an increasing awareness of true feelings abour the marriages occurred. There were no differences in husband-wife discrepancy scores in overall satisfaction as a function of Severity Of Abuse Index, abuser status, or treatment choice.

During their involvement with the project, several marriages had a separation occur. With such a relatively unhappy group of wives involved, some separations could be expected and these may have been successful treatment outcomes.

Self Esteem Scores

A discussion of self esteem scores at the beginning of treatment is contained in the Treatment of Adults section under the "clinical profile of the adult." Changes in self esteem and self esteem satisfaction scales were not significant. Of the 24 adults who had initial and final self esteem scores, so that changes could be computed, 8 were already in the high self esteem group. Of the 16 who could have moved upwards, 8 moved upwards and 2 moved downwards. Thus, only half of the adults who could have improved their self esteem rating did so. This contrasts with the children's results, where all the children who could have improved their ratings did so.

Project Social Worker's Utilization of Research Data

The process of involving the client in the collection of research data and sharing the analyzed data with the client proved to be advantageous in several areas. It was helpful to the physical mechanism of data collection, in that the social worker could insure the completion of the questionnaire. With regards to treatment issues, it served three major purposes, (1) strengthened the therapeutic relationship, (2) opened up new directions for the focus of treatment, and (3) provided a medium for future re-evaluation.

When the therapist asked the client to participate in the research study by filling out the packet of questionnaires, the client-therapist relationship often underwent a subtle change. Previously, the abusive client had often related to the social worker much the way a young child would relate to the omnipotently perceived parent. The process of having the therapist ask for answers from the client changed this dynamic. The therapist was no longer omnipotent and the client was no longer in the child-like role of needing answers. The client was given permission to express how he perceived himself and the therapist's role was to accept that definition.

A secondary benefit was gained when the therapist shared the results of the analyzed data with the client. The therapist would report how the client depicted himself and then ask for feedback in terms of agreement or disagreement with the computer's analysis. Sometimes the assessment would match how the client perceived himself/herself. This would usually be reaffirming to the client and provide an opening for considering ways to change this perception, if it were a negative one. If, however, the client was in disagreement with how he/she was described, then this necessitated exploring reasons for the discrepancy. Often this would provide an opportunity for the therapist to make an interpretation of the client's resistance, such as, "you tell me that you have a good marital relationship, yet your responses to these questions indicate that you are dissatisfied with your spouse." These opportunities helped the therapist confront the client's use of denial as a defense and then to consider new avenues of awareness and ways to implement change.

The final benefit of sharing the research results with the clients was that it provided a regular basis of treatment re-evaluation. If the six month analysis consistently showed that the client had poor self esteem, the therapist could use that information to ask the client, "Has this treatment plan involved any positive change for you?" Evaluations such as these, on a regular basis are instrumental in making the client and therapist accountable to seeking new patterns of growth.

Intellectual and Developmental Testing of the Children

Results of Testing

As a part of the evaluation of the program, psychological testing was done on as many children associated with the Family Center as was possible. Some children were not tested in the Crisis Nursery Program because of their very short placement there. They were tested soon after they came into contact with the Family Center. Retests were given after one year or upon termination, whichever came first. Children whose initial testing occurred within the last six months of the project were not retested, since a period of at least six months was considered necessary to detect valid changes in cognitive development. All retests occurred between six months and eighteen months after the initial testing. Children under the age of two years were given the Bayley Scales of Infant Development. Children over two years of age were tested on either the McCarthy Scales of Children's Abilities (MSCA), or the Wechsler Intelligence Scale for Children - Revised (WISC-R). All three of these are tests of cognitive development which have been standardized on large samples of the general population. The WISC-R yields an Intelligence Quotient (IQ); the McCarthy, a General Cognitive Index (GCI); and the Bayley, a Mental Developmental Index (MDI); all of which have 100 as their mean score. The standard deviation of the WISC-R IQ is 15 points, while on the McCarthy and the Bayley, the standard deviation is 16 points. The Bayley is standardized for children up to 2½ years. The McCarthy is standardized for children between 2½ and 8½ years of age, and the WISC-R for children from 6-16 years of age. Thus, the children in the Family Center Project were given the test which was most appropriate for their age.

A total of 70 children were tested. Of these, 27 were residents of the

Crisis Nursery, and 43 were in the caseload of the Family Center or in the Adams County Department of Social Services' caseload, but receiving some treatment through the Family Center. Table 19 shows a breakdown of the total number of children tested by test administered and overall treatment category, The "Treatment" group includes all children who received some treatment (other than Crisis Nursery placement) from the Family Center. The "Non-treatment" group includes all children on the caseload of the Family Center who did not receive direct treatment, but whose parents were in treatment, or the family received some other service from the Family Center.

Of the 70 children tested initially, 35 were retested and have change scores available. Several more children were retested, but because their retest was on a different test than their initial test, due to changes in age that put them out of the scoring range of their initial test, test-retest comparisons were not possible. Therefore, they are not included in this analysis. Table 20 shows a breakdown of all children retested on the same test as their initial one, according to test administered and overall treatment category.

Retesting was done on all children initially tested who were eligible and available for retesting. Those who were ineligible were those whose initial testing was done within the last six months of the project for the reason given above. Those who were not available for retesting had either moved out of the metropolitan Denver area, been placed in residential treatment outside of the Denver area, or the parents refused retesting.

Forty-three, or 61 percent, of the total number of children tested were males, and 27, or 39 percent, were females. At the time of their initial testing, the children ranged in age from:

TABLE 19

Total Number of Children Tested

	Bayley	MSCA	WISC-R	Total
Crisis Nursery	8	10	9	27
Treatment	0	14	9*	23
Non-treatment	4	11	5	19
Total	12	35	23	70

*Nine have verbal, performance, and full-scale IQ scores; subtest scores are missing for one child.

TABLE 20

Number of Children Tested and Retested On Same Test

	Bayley	MSCA	WISC-R	Total
Crisis Nursery	3	4*	5	12
Treatment	0	8*	5	13
Non-treatment	3	6	1	9
Total	6	18	11	35

*1 less on motor subtest

0 yrs., 2 mos.---12 yrs., 10 mos. in the Crisis Nursery
2 yrs., 7 mos.---14 yrs., 8 mos. in the Treatment Group
0 yrs., 5 mos.---12 yrs., 9 mos. in the Non-treatment Group

Several children who were temporarily placed in the Crisis Nursery while receiving other treatment from the Family Center were included in the "Treatment" group in this analysis.

Scores on the different tests cannot be compared because of different standard deviations. Thus, the test data will be discussed according to which test was administered. The following tables describe the test data in terms of mean scores, intelligence classifications, and mean change scores. Numbers and percentages of children showing score increases and decreases are also given. Changes on overall and subtest scores were analyzed for significance, and comparisons between Crisis Nursery, Treatment, and Non-treatment groups were made on initial testing and change scores. Differences by age and sex were also analyzed as were differences by the Severity of Abuse Index. All significance tests were run at p=.05. Thus any differences described as significant are significant at the .05 level or better.

Statistical analyses of mean scores at initial testing were completed on all children initially tested on each test and on those children in the Crisis Nursery, Treatment, and Non-treatment groups. At retesting, mean scores and change scores were statistically analyzed only for the total number of children retested on a given test. The breakdown of children retested on a given test in Crisis Nursery, Treatment, and Non-treatment groups yielded numbers that were too small for valid statistical analyses. Rather, changes in test scores for children within these groups were tabled according to the number and percent of children showing score increases and decreases (Refer to Tables 5 and 7).

Results of Initial Testing (Bayley)

Twelve children were initially tested on the Bayley, six males and six females. The mean Mental Development Index (MDI) of these children was 105, and the median was 109. Only three scored less than 100. All children tested scored between 89 and 122. At the initial testing, there was no difference between the Crisis Nursery group and the Family Center caseload children. There was no difference in scores by abuse index or by sex. Because these children were all 2½ years of age or younger, none received treatment themselves other than Crisis Nursery Placement. Thus, there is no breakdown of treatment/non-treatment other than Crisis Nursery versus Caseload. Nine of the 12 children tested were potential abuse cases, and only one was severely abused.

Results of Retesting

Six children of the 12 originally tested were eligible and available for retesting (five males and one female). A plus/minus test revealed that there were no differences on the initial testing between those children retested and those not retested. All children tested and retested showed gains at retesting. The range of these gains was 1 point to 17 points on the MDI. The mean increase was 8.8 points, and the median was 7 points. The mean gain (8.8 points) is significantly different from zero at the .05 level or better. There was no difference in gains due to sex, abuse index, or treatment (i.e., Crisis Nursery compared with caseload children).

From this data it was concluded that these children looked normal in their cognitive development at the time of initial testing and that all who were retested showed improvement at retesting.

Results of Initial Testing (MSCA)

A total of 35 children were initially tested on the MSCA. Of these, 25 were males and 10, females. Examining the initial test scores, their mean scores were significantly lower than those for the normal population in all areas measured by the MSCA (Verbal, Perceptual-Performance, Quantitive, GCI*, Memory, and Motor). Their mean scores are shown in Table 21 . Although their verbal scores were lower than their perceptual-performance scores, the defference was not statistically significant. The only difference by sex was that females scored significantly higher than males on the Quantitative subtest. There were no significant differences in scores between the Crisis Nursery children and the Family Center caseload children at the initial testing. Furthermore, there were no significant initial test differences within the caseload children between those who received treatment and those who did not.

Thus project children between 2½ and 8½ years of age generally showed initial cognitive deficits in all areas tested, with slightly greater problems in verbal skills than perceptual-performance skills.

Results of Retesting - (MSCA)

Of the 35 children initially tested on the MSCA, 18 were eligible and available for retesting. A plus/minus test demonstrated that those children retested were not significantly different on their initial testing from those not retested. The total group of children restested showed significant gains on the Verbal subtest, Perceptual-Performance subtest, and the GCI. There were no significant changes on the Quantitative, Memory, and Motor subtests.

For the total 18 children retested, the gains made in Perceptual-Performance skills were sufficient to bring the mean scores at retesting up to average. The gains made in Verbal and GCI scores, however, were not. The mean Verbal and GCI scores at retesting were still significantly below the normal population means (Refer to Table 21). At the time of retesting, then, the mean scores of all children retested on the MSCA were still significantly less than the means for the normal population on the Verbal, Quantitative, and Memory subtests, as well as on the GCI. Their Perceptual-Performance and Motor mean scores were equal to, or slightly greater than, those in the normal population.

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* The GCI is an overall score of cognitive development, comprised of the Verbal, Perceptual-Performance, and Quantitative scores.

At the time of retesting the total group of children retested showed a significant difference between their Verbal and Perceptual-Performance subtest scores, with Verbal scores lower then Perceptual-Performance scores (V - P 0 at .05 level or better). On the initial testing the total group showed this same difference, but not to a statistically significant extent. This indicates that, while the children retested made significant gains in both verbal and perceptual-performance skills, their perceptual-performance skills became significantly stronger than their verbal skills. This suggests that they made greater gains in areas that were relatively stronger in the first place. Because their Verbal scores were still below average at retesting, in spite of their gains, it appears that these children had more difficulty making gains in the verbal sphere than the nonverbal.

Males showed a significantly greater change in Verbal, GCI, and Memory scores than did females. Since they did not differ significantly from females at the initial testing, it may be concluded that males improved in these areas to a greater extent than females.

Since the number of children retested was too small to allow meaningful statistical analyses of the retests broken down into Crisis Nursery (n = 4), Treatment (n = 8), and Non-direct treatment (children whose parents were

TABLE 21

Results of Testing on McCarthy Scales of Childrens' Abilities

Mean Scores - MSCA

		Verbal	Perceptual Performance	Quantitative	GCI	Memory	Motor
INITIAL TESTING	Crisis Nursery (n = 10)	42.8	48.0	41.6	89.9	42.9	49.8
	Treatment (n = 14)	42.6	44.9	38.9	86.4	42.2	43.6 (n = 13)
	Non-treatment (n = 11)	42.4	43.5	43.9	86.9	44.8	45.3
	Total (n = 35)	42.4*	45.3*	41.1*	87.2*	43.1*	46.1* (n = 34)
Retest	Total (n = 18)	45.7*	51.6	43.2*	93.7*	43.3*	50.1
Change Scores	Total (n = 18)	+3.8**	+5.8**	+2.6	+6.8**	-.2	+3.5

*Significantly lower than normal population means at .05 level or better.
**Significantly different from zero change at the .05 level or better.

receiving treatment, n = 6) groups, the above statistics were computed for all children retested on the MSCA. Table 22 shows a breakdown of Crisis Nursery Treatment and Non-treatment children retested on the MSCA, showing what number and percent of each group had score increases or decreases from initial testing to retesting. Seventy-five percent of the Crisis Nursery and Treatment children showed gains in Verbal and Perceptual-Performance scores, while 83 percent of the Non-treatment children showed verbal gains, and 67 percent showed perceptual-performance gains. While 50 percent of the Crisis Nursery and Non-treatment children showed gains in GCI, 63 percent of the Treatment children gained in GCI. Numbers and percentages of children in each group showing increases, decreases, or no change can be obtained from Table 22 for all MSCA subtests and the GCI. From the MSCA test and retest results, it was concluded that at the age at which these children were initially tested (2½ years to 8½ years) they showed significant cognitive deficits in all areas tested by the MSCA. Their retests indicate that these children on the average made significant gains in their cognitive skills in at least the Verbal and Perceptual-Performance areas and thus the GCI as well. On the other hand, there were some children who showed decreases in certain skills (Refer to Table 22). While these children were far fewer in number, they are of concern, but the information or knowledge to say why they decreased is not available. A much larger percentage of the children showed increases than decreases in their Verbal, Perceptual-Performance, and GCI scores. On the Quantitative, Memory, and Motor subtests, slightly more than half of the children showed gains and less than half showed losses. Thus, it seems that gains were more frequent and perhaps easier to achieve in the Verbal and Perceptual-Performance skills than in the other areas.

TABLE 22

Number and Percentage of Children Showing Test-Retest Increases or Decreases on the MSCA

	Verbal		Perceptual Performance		Quantitative		GCI		Memory		Motor	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Crisis Nursery (n = 4)	3↑	(75)	3↑	(75)	2↑	(50)	3↑	(75)	2↑	(50)	2↑	(67)
	1↓	(25)	1↓	(25)	2↓	(50)	1↓	(25)	2↓	(50)	1↓	(33)
	0=	(0)	0=	(0)	0=	(0)	0=	(0)	0=	(0)	0=	(0) (n = 3)
Treatment (n = 8)	6↑	(75)	6↑	(75)	5↑	(63)	5↑	(63)	4↑	(50)	4↑	(57)
	2↓	(25)	2↓	(25)	3↓	(38)	2↓	(25)	3↓	(38)	2↓	(29)
	0=	(0)	0=	(0)	0=	(0)	1=	(13)	1=	(12)	1=	(14) (n = 7)
Non-Treatment (n = 6)	5↑	(83)	4↑	(67)	3↑	(50)	6↑	(100)	3↑	(50)	3↑	(50)
	0↓	(0)	2↓	(33)	3↓	(50)	0↓	(0)	2↓	(33)	3↓	(50)
	1=	(17)	0=	(0)	0=	(0)	0=	(0)	1=	(17)	0=	(0)
TOTAL (N = 18)	14↑	(78)	13↑	(72)	10↑	(56)	14↑	(78)	9↑	(50)	9↑	(56)
	3↓	(17)	5↓	(28)	8↓	(44)	3↓	(17)	7↓	(39)	6↓	(38)
	1=	(5)	0=	(0)	0=	(0)	1=	(6)	2=	(11)	1=	(6) (n = 15)

Note: ↑ indicates increase in score.
↓ indicates decrease in score.
= indicates no change.

The Other Areas

While the Perceptual-Performance and Motor gains were enough to bring the children's mean scores up to average, the gains in Verbal skills were not. Although at retest the verbal skills still were below normal for these children, their non-verbal skills were not different from their peers'. It is not known whether these children will continue to improve over time. Only longitudinal research with larger numbers of children can answer this question.

Results of Initial Testing (WISC-R)

Upon initial testing, the mean scores of the 23 children tested on the WISC-R through the Family Center were significantly lower than those in the normal population on several subtests: Information, Arithmetic, Vocabulary, Digit Span, and Coding. Four of these are verbal subtests, while one (Coding) is a performance subtest. Their mean verbal and full scale IQ's were also significantly lower than those in the normal population, but their mean Performance IQ was not.* Indeed, one Performance subtest, picture arrangement , was significantly above average. As might be expected given this pattern of results, the Verbal IQ of these children was significantly lower than their Performance IQ, at the time of the initial testing. This pattern is similar to that seen in the younger children, tested on the MSCA, but is significant for the older children tested on the WISC (the difference was in the same direction, but not significant for the younger children).

The pattern of the subtest scores of all of the children initially tested on the WISC-R indicated that their deficiencies were in the subtests that reflected academic learning and those subtests most affected by anxiety.

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* The Verbal IQ is a composite of five Verbal subtests, and the Performance IQ is a composite of five Performance subtests. The Full-Scale IQ is a combination of the Verbal and Performance IQ's.

From the experience of testing these children it appeared that their strengths and weaknesses followed a common pattern. This pattern followed logically what is known about the nature of the abusive environment and its effect on learning. To investigate this further, several factors were devised that seemed to measure the cognitive patterns of interest. This was done by averaging the scores on several WISC-R subtests for each child. Several hypotheses were formulated concerning the relationship of these factors. Listed below are the factors and the subtests they are composed of:

Factor Name		Subtest Included
Academic Learning	=	Information + Arithmetic + Vocabulary
Reasoning Ability	=	Similarities + Object Assembly + Block Design
Social Perception	=	Comprehension + Picture Completion + Picture Arrangement

The hypotheses were that abused children would show: (a) average scores on Reasoning Ability, (b) average or better scores on Social Perception, (c) less than average scores on Academic Learning, (d) significantly lower Academic Learning skills than Reasoning Ability, and (e) significantly lower Academic Learning than Social Perception. To test these hypotheses on the total group of children initially tested, scores were computed for each child on each factor, as were difference scores between each two factors which were compared. Then group means were computed and compared to the expected mean for the normal population. Mean differences between factors were compared to an expected mean difference of zero.

The findings were:

(a) These abused children showed average ability on the Reasoning Ability factor.

(b) They showed average ability on the Social Perception Factor.

(c) They showed significantly less than average scores on the Academic Learning factor.

(d) They showed a significantly lower Academic Learning scores than Reasoning Ability scores.

(e) They also showed significantly higher Social Perception scores than Academic Learning scores.

Thus, all hypotheses were confirmed at the .05 level or better. It is important to note, however, that most of the differences found, while statistically significant, were not large in actual point values. They ranged between 1 and 2 scale score points.

At the time of initial testing, there were no differences in scores by sex or by severity of abuse index. There were no differences between the caseload children who received treatment and those who did not. There were, however, several significant differences between the children in the Crisis Nursery group and the caseload children. These Crisis Nursery children showed significantly lower scores on Similarities, Digit Span, Vocabulary, Arithmetic, Picture Arrangement, Block Design, Performance IQ, Verbal IQ, and Full Scale IQ than the caseload children (Refer to Table 23). These Crisis Nursery children showed cognitive deficits in many areas when compared to other abused children. This finding was in contrast to the children tested on the Bayley and the MSCA. The Crisis Nursery children in those groups were not significantly different from the caseload children. There are at least two major hypotheses that could explain these differences, and

TABLE 23

Mean Scores - WISC-R

		Verbal IQ	Performance IQ	Full-Scale IQ
INITIAL TESTING	Crisis Nursery (n = 9)	85.6*	93.7*	88.8*
	Treatment (n = 9)	96.8	102.2	99.0
	Non-Treatment (n = 5)	93.4	102.6	97.6
	TOTAL (N = 23)	91.7**	99.0	94.7**
RETEST	TOTAL (N = 11)	86.1**	104.3	93.4
CHANGE SCORES	TOTAL (N = 11)	-1.5	+7.0***	*2.3

*Significantly lower than the treatment and non-treatment groups at .05 level or better.

**Significantly lower than the normal population mean at .05 level or better.

***Significantly different from zero change at the .05 level or better.

both have to do with the fact that the WISC-R children were older than the MSCA and Bayley children:

(1) It may be that older children who have spent more of their formative years in an abusive environment show effects of this more strongly than the younger ones. Thus older children whose environments were bad enough to warrant the child's removal and placement in the Crisis Nursery may show greater cognitive deficits than their peers whose environments were not bad enough to result in removing the child to the Crisis Nursery. That is, if the older children in the Crisis Nursery came from more depriving home environments than the older caseload children, and/or have spent a longer period of time in an abusive environment than the younger children, it is assumed that they would show greater cognitive deficits at initial testing.

(2) It may be that because the WISC-R children were older than the MSCA and Bayley children, they may have been more strongly affected, in some ways, by placement in the Crisis Nursery than were the younger children placed there. They were likely to be more aware of the significance of their placement, i.e., that it reflected a pathological home environment. They were also likely to better understand the implications of their placement, i.e., that they might be permanently removed from their homes, or that there might be other ramifications upon their return home. If the older children were indeed more affected in these ways, it is likely that their cognitive functioning would have been depressed, regressed, or otherwise disturbed at the time of their initial testing in the Crisis Nursery, thus giving an inaccurately low measurement of their abilities.

Either of these explanations could be responsible for the WISC-R children in the Crisis Nursery showing lower scores than the caseload WISC-R children. The experience of testing these children suggests that at least some of the children tested in the Crisis Nursery were so disturbed that they did not seem to be doing their best on the testing. Although this occurred with other children as well, there seemed to be more effects on test scores due to emotional interference in the Crisis Nursery group.

The differences between the caseload and Crisis Nursery children indicated that initial test differences between the total group tested and the normal population were attributable mainly to lower Crisis Nursery scores. Only the Crisis Nursery children and not the caseload children showed significant cognitive deficits at the time of initial testing (Refer to Table 23).

Results of Retesting (WISC-R)

A plus/minus test comparing the initial scores of those children retested and those not reveals that the only scores that were significantly different were the Information and Similarities, and both are Verbal subtests. Those not retested scored higher on the initial testing. Neither of these differences affected Verbal IQ nor Full Scale IQ. Since there were no differences on Performance subtests, Performance IQ was obviously not affected.

Eleven of the 23 children originally tested were available and eligible for retesting. Because this number was quite small for statistical analyses, it was possible to do statistical analyses only on this total number of children retested. The number of children retested in each treatment group (Crisis Nursery, n=5, Treatment, n=5, Non-treatment, n=1) was too small to allow valid statistical comparisons. Therefore, changes in children's scores, according to treatment group, were investigated by looking at the number and percent of children in each group who showed score increases, decreases, or no change (refer to Table 24).

At the time of initial testing, the total number of children tested on the WISC-R showed mean scores significantly less than those in the

TABLE 24

Intelligence Classifications for all Children Tested

		Mentally Defecient (IQ<70)		Borderline (IQ=70→79)		Low Average (IQ=80 89)		Average (IQ=90→109)		High Average (IQ=110-119)		Superior (IQ 120)		TOTAL	
		no.	%	no.	%	no.	%	no.	%	no.	%	no.			%
INITIAL TESTING	MSCA (n=35)	1	(3)	9	(26)	12	(34)	12	(34)	1	(3)	0	(0)	35	(100)
	WISC-R (n=23)	0	(0)	2	(9)	7	(30)	12	(52)	1	(4)	1	(4)	23	(100)
	TOTAL (N=58)	1	(2)	11	(19)	19	(33)	24	(41)	2	(3)	1	(2)	58	(100)
RETEST	MSCA (n=18)	1	(6)	1	(6)	3	(17)	12	(67)	1	(6)	0	(0)	18	(100)
	WISC-R (n=11)	1	(9)	1	(9)	2	(18)	6	(55)	1	(9)	0	(0)	11	(100)
	TOTAL (N=29)	2	(7)	2	(7)	5	(17)	18	(62)	2	(7)	0	(0)	29	(100)

normal population on 4 Verbal subtests (Information, Arithmetic, Vocabulary, and Digit Span), Verbal IQ, and one Performance subtest (Coding). On the retest, the 11 children retested continued to show significantly lower means than the normal population means on the same Verbal subtests and on Verbal IQ. Their mean coding score, however, was not lower than average at retesting.

The mean Full Scale IQ of those initially tested (94.7) was significantly lower than the normal population mean of 100. However, the mean score of those retested (93.4) was not significantly lower than 100, because it was based on a smaller number of children with a larger standard deviation.

The only area in which the total group of children retested showed significant positive change scores was Performance IQ, which was already average at the initial testing. They showed significant negative change scores on the Vocabulary subtest. None of the other subtests, or the Verbal IQ, or the Full Scale IQ change scores were significantly changed in either direction. Thus, the older children, tested on the WISC-R, did not show the same positive changes in cognitive functioning that the younger children tested on the Bayley and MSCA did.

The significant difference between Verbal and Performance IQ's which the WISC-R children showed upon initial testing, continued to be present at retesting. The total group of children retested still have significantly lower Verbal scores than Performance scores. In fact, the difference between their Verbal and Performance IQ's was significantly greater on the retest. This is due to the fact that there was a significant positive mean change in Performance IQ while the Verbal IQ mean change was negative, although not significantly so. Thus, these older children improved in the areas which were relatively stronger to begin with and remained deficit in their initially weaker area, the verbal area.

There were no significant differences in change scores attributable to severity of abuse. The only significant differences between males and females were that males showed increases on the Digit Span and Block Design subtests while the females showed negative changes on those two. There was a trend, although not quite significant, for males to gain and females to lose on Verbal IQ.

Because there was only one child retested in the Non-Treatment group, there is no way to determine whether change scores were any different for children who received direct treatment than for children whose parents only received treatment. To compare the children within the Crisis Nursery group to those in the Treatment group, and the one in Non-treatment, the numbers and percentages of children in each group who showed IQ increases or decreases have been tabled (refer to Table 24).

The numbers and percentages of children showing changes in each direction was approximately equal in the Crisis Nursery and Treatment groups. Two-thirds of the total number of children retested on the WISC-R showed decreases in Verbal IQ, while only one third showed increases. However, 73% increased their Performance IQ while only 27% decreased. These older children continued to improve in their areas of strength, nonverbal areas, but showed a decline in the verbal area.

To summarize the WISC-R results, upon initial testing, abused children of age seven and above who were placed in the Crisis Nursery had significantly greater cognitive deficits than the caseload children of seven and above.

These Crisis Nursery children influenced the mean scores of all those initially tested so that the mean Verbal IQ and Full Scale IQ of the total group were both significantly less than the means in the normal population. It was concluded that the total group of children retested showed significant increases in Performance IQ and slight, non-significant decreases in Verbal IQ. The mean Verbal IQ at retest was significantly lower than normal and four points lower than it was at the initial testing. All of this leads to the conclusion that these abused children's initial cognitive strengths were improved, but their initial weaknesses remained.

Summary, Conclusion and Discussion

Table 24 shows the frequency distribution on Intelligence Classification of all children tested through the Family Center, excepting those tested on the Bayley, for whom intelligence classifications were not available. From this table it can be seen that there is a general trend of improvement in overall cognitive development among the children tested on the MSCA. There is less evidence of any change trend among the older children tested on the WISC-R. There is an optimal age for intervention with children to produce cognitive change. The younger intervention occurs, the more the change.

The children tested on the Bayley were average, or above average, in their cognitive development at the initial testing. They also showed significant score increases on the retest.

There are two sources of data on Bayley results whose findings are not in agreement with ours. Rodeheffer, in a verbal communication to the project, reported findings of cognitive deficits in infants tested at the National Center for the Prevention and Treatment of Child Abuse and

Neglect, all of whom were severely or moderately abused. Gaensbauer, in a verbal communication, reported the same cognitive defects in a group of 24 children who were severely or moderately abused, and were referred to him from the department of social services' caseload. He remarked that the mild and potentially abused children from the project caseload did significantly better on cognitive testing than their age mates who were more severely abused. In addition, the project children were the only group to change significantly upon one year retest. The more severely abused children tested by Gaensbauer remained the same, or decreased in cognitive development. Thus, if potentially abused children were found as infants, they had no measureable cognitive deficits at that time. They may continue to function well, providing intervention occurs in their families. In contrast, older potentially abused children tested by the project had cognitive deficits no different from children who were actually abused.

The children initially tested on the MSCA showed no significant differences between the Criris Nursery, Treatment and Non-treatment groups. Scores for the total group showed cognitive deficits in all areas tested. Upon retest, the children showed significant Verbal, Perceptual-Performance and GCI gains, but their mean Verbal, Quantitive, Memory and GCI scores remained significantly lower than expected in the normal population. Their Performance and Motor skills were average at retesting. Abused or potentially abused children tested between two and one half and eight and one half years showed cognitive deficits in all areas tested, but they had minimized these deficits between six months and one and one half years later. They were able to improve the deficits in non-verbal areas, but verbal skills continued to be a problem, although gains were made.

The children initially tested on the WISC-R demonstrated that at seven years of age and above, children placed in the Crisis Nursery showed cognitive deficits which account for total initial scores being significantly less than expected in the normal population. The Crisis Nursery children were significantly lower in many areas than the caseload children. Their mean Verbal IQ was significantly less than their mean Performance IQ. At retesting, the only significant overall change was in Performance IQ, which increased. The difference between Verbal and Performance IQ was also increased.

Thus, while the younger children showed more widespread deficits on the initial testing, they showed greater capacity to improve their cognitive skills by the time of retesting. The older children showed less likelihood of significantly improving their deficit areas. This emphasizes the need for early intervention. The most significant finding in favor of early intervention was the fact that only in the two and one half or younger group, had the potentially abused children been spared the cognitive deficits found in older groups who had lived longer in potentially abusive environments.

A chi square comparison of younger and older children on direction of change in Verbal scores demonstrated a significant difference. Among the children tested, significantly more younger children showed verbal score increases, and significantly more older ones showed verbal score decreases (chi square=3.36, p .05). While the younger children's verbal scores remained less than average at retesting, at least they moved in a positive direction. The older children had more verbal deficits than normal children. Thus, verbal skills were deficit in these children, and the deficits may increase as the children grow older. There was some indication in both the younger and older groups that males tended to show greater increases in skills, particularly verbal, upon retesting.

An analysis of subtest score patterns of WISC-R children at the initial testing revealed that this group of abused children showed average Reasoning Ability and Social Perception, but that their Academic Learning was less than average. The very important implication of this is the suggestion that the cognitive deficits seen in abused children may be more the result of deficits in learning than deficits in ability. It is hypothesized that due to the nature of the abusive environment, abused children do not have the energy or motivation to devote to cognitive learning in many areas, and that they devote more energy to understanding their social environment. Thus, if they were of average ability to start with, the pattern of average reasoning and social skills with deficient academic skills would develop.

In terms of the major hypotheses of this study, older children did show more deficits than younger children and changed less. Girls did not have significantly better cognitive functioning than boys, and did not improve more. In fact, the differences found, though slight, were in favor of the boys. Results on the Severity of Abuse Index showed that only in the children under the age of two and one half were the potentially abused children doing better than actually abused children. After that age, there wereno differences in cognitive functioning due to severity of abuse. The crucial variable seems to be the length of time spent in a non-physically and emotionally nurturing environment.

Behavioral Observations - Children Under the Age of 2½

Dr. Ted Gaensbauer and his colleagues at the University of Colorado Medical Center did behavioral observations and Bayley Testing on 37 abused or neglected children under the age of 2½ years. Thirteen of these 37 children were Family Center project children, the other 24 were from Department of Social Servicecaseloads in the Denver area. Gaensbauer's group also made the same observations on a large number of normal infants; thus, comparisons between abused or neglected children and normals can be made.

Dr. Gaensbauer made a part of an unpublished article describing his work available to the project. Although only about 1/3 of the children in his sample were Family Center chidlren, he was unable to distinguish any major differences in behavior between Family Center children and the other abused children. As mentioned previously, the Family Center children, who were for the most part potentially abused, scored significantly higher on the Bayley test than did the Department of Social Service children. However, since no consistent ways in which these potentially abused project children differed in behavior from their actually abused peers were observed, the behavioral observations provided by Gaensbauer have been included in this report. In addition to ovservations made during testing on the Bayley, the infants were observed during free play, mother-infant interactions, stranger-infant interactions and separation-reunion experiences.

Behavior During the Bayley Testing of Abused or Potentially Abused Infants

The infant often seemed unable to maintain the sustained attention necessary for completion of the test items. The frequent substitution of test items required by the testing situation led to frustration, overt angry reactions, or regressed fussing. Withdrawal would frequently follow the removal of a toy, if another test item were not immediately available. Difficulties in cooperating involved not only intentional resistance, such as that described by Martin and Rodeheffer, but by passive inattention as well. Being unaccustomed to interactions with adults, these infants would often pay little attention to the examiner's requests. Successful performance on a particular item would depend on catching the infant's attention during the relatively brief window in time that he would be willing to pursue the task. As a result, considerable test scatter was seen.

The response to a mild verbal prohibition could also be quite striking. Some infants responded with a marked temper outburst. However, several infants responded with an instant freezing reaction associated with a fearful or sad expression which persisted until the examiner reassured the infant.

Free Play. Most infants actively explored the room and the toys, although their play lacked the animated, persistent, and creative qualities of our normative sample. Instead, it appeared disorganized. An aimless or restless quality, with a lack of ability to sustain attention or interest in specific items was typical. A number of infants showed marked inhibition in activity. In some, this was associated with "frozen watchfulness" accompanied by frequent uneasy glances toward mother, while in others it seemed related to depressive qualities of listless motoric retardation and lack of energy. This was in marked contrast to the play of normal infants who actively combine objects, make them work appropriately, and use them to produce interesting effects. Only those infants who were rated as "ambivalently attached" (Harmon, Durfee, Klein, 1976) in a normative sample showed the aimless movement from toy to toy that was often observed in these infants.

Affective Responses. Utilizing judgements based on facial expressions and behavior, the presence and intensity of the emotions of pleasure, interest, fear, anger, and sadness during the sequence were recorded. These showed differences from normative samples both in the quality of the responses and the manner in which such responses were modulated. For example, pleasurable responses during the free play and testing situations were less evident than in the normative sample. At the same time, overt expressions of fearfulness during the stranger approach were less often seen, and distress responses to mother's leaving the room were less evident than in the normative sample. At the same time, overt expressions of fearfulness during the stranger approach were less often seen, and distress responses to mother's departure were the rule. Unusual affective responses were present at times which were not often seen in a normative sample. For example, unlike in the normal population, fearfulness or sadness could be observed during the free play situation, and expressions of anger were much more frequent throughout. In terms of modulation of affect, these infants showed two deviant patterns. Some infants showed a quite narrow range of affect, with little affective response regardless of the situation. Other infants showed a tendency to erupt with very strong and quite destructive displays of affect, particularly anger.

Mother-Infant Interaction. Reciprocity of mother-infant interaction seemed impaired. The behavior of mothers varied widely. Some mothers were quite uninvolved with their infants, doing little to make them feel comfortable. Other mothers made valiant though somewhat forced efforts to interact with their infants. Mother-infant interaction at home was often revealed in the child's response. Mother may have tried to make contact, but if the child were unaccustomed to this type of interaction, he would not respond. The result was a kind of parallel play in which sustained reciprocal interactions were rare. Interestingly, this was often the case with foster mothers as well; despite sensitive efforts to engage the infants, these children were often unresponsive. When social contact was largely left to the infant's initiative, attentiveness to mother in the form of proximity seeking and verbal and social bids for attention were less frequent than in the normal population. Mother was not used as a "secure base" as has been described for normal infants (Ainsworth).

Mother-Stranger Comparison. There are two occasions when direct comparisons of the infant's response to a stranger versus mother can be made--during the approach and pick-up phase and later during separation and reunion. Though in a normal sample, many infants will show positive reactions to strangers, and will not be unduly upset by mother's departure, the preference for mother is clear. It is extremely rare for a normal infant to show more attachment behavior and positive responding to a stranger as compared to mother. Such reactions were not uncommon in the abused sample. Indeed, in approximately 20% the response to the stranger was more positive than to mother, while an additional 40% responded similarly to both mother and stranger; only 40% were clearly more positive to mother.

Separation and Reunion. Observations of these infants' reaction to mother's departure and reunion largely supported the hypotheses of Ainsworth and her colleagues (Ainsworth, Bell, and Stayton, 1971, etc). According to these investigators, a lack of search or distress behavior following mother's departure, and the lack of positive greeting with resistance to, or avoidance of, the mother following reunion reflects insecure and/or ambivalent infant attachment. These infants showed relatively little distress when mother left the room. When distress was evident, it included an angry component which often persisted following mother's return in the form of avoidance or provocative attention-seeking behavior. The comparison of the infants' responses to a separation from, and reunion with, the stranger as contrasted with mother was at times quite striking. In our normal sample, despite frequent positive interactions with the stranger up to this point, we have not observed any infants who show more positive attachment behavior during separation or reunion to the stranger as compared to mother. In the abused and neglected infants tested with their natural mothers, six infants have shown more positive "attachment behaviors" to the experimenter than to mother, including search behaviors following departure, and positive approach behaviors following reunion.

Behavioral Observations - Children above the Age of 2½

When compared to the general child population, abused children typically show a much higher frequency of deficits in cognitive development. The psychologists who did the cognitive testing of children in the Family Center project have noted a number of behavioral characteristics in these children that made it difficult to accurately assess their cognitive abilities. These behavioral patterns interfered with the child's ability to perform in the testing situation, and presumably with their learning in school as well. Many of these interfering behaviors suggested the likelihood of future difficulty succeeding in socially acceptable channels. Certain of these behaviors, for example, would make good school performance difficult and cause poor relationships with teachers and other figures in the school setting.

Below are listed various behavioral characteristics observed in the children above the age of two and one half tested through the Family Center. They are grouped into conceptual categories and there may be overlap, in that specific behaviors may appear in more than one category. In actuality, of course, the behaviors did not occur in isolation, but were observed as parts of the child's personality and coping style. These behaviors were crucial in considering whether test results accurately assessed cognitive potential, and in projecting the direction of future development.

Relationship to Examiner. Whether or not a relationship was formed, and the quality of the relationship were important factors in assessing the validity of test scores. Below are the various problems in relating to the examiner which were observed in these children.

1. No relationship formed. There appeared to be several types of children who did not form relationships with the examiner:
    a) Depressed, withdrawn children who showed little interest in other people or activities
    b) Distrustful, defensive children who appeared sullen or fearful of relating to the examiner and/or the situation
    c) Children who seemed truly uninterested in relating. These children appeared to have given up trying to relate to adults at all, rather than just being fearful or depressed.
2. Problematic ways of relating. There were also several ways of relating to the examiner which interfered with test performance. One child may have exhibited more than one of these qualities:

a) Hostile, aggressive responses to the examiner, where the examiner became the recipient of the child's anger. This angry response varied in intensity and style of expression from child to child. It may have included overt demands, testing of examiner, and verbal and/or physical expressions of anger.

b) Clinging, affection seeking and indiscriminate attachment of the child to the tester. The attachment was melodramatic and superficial, and was more indicative of the child's intense needs for attention and affection than of a healthy interpersonal relationship. This behavior was usually self-defeating as it became aversive to the examiner and others who dealt with the child, thereby lessening the likelihood that the child's needs will be satisfied.

c) An intense eagerness to please the examiner. The main motivation in this sort of child's behavior throughout the testing was to find out what the examiner wanted and to offer that. Their eagerness to please and to meet the needs of adults may be adaptive at home, but was dysfunctional in the testing or learning situations. The relationship with the examiner was superficial, but highly important to them, and their energy was focused there rather than on test performance. This was often accompanied by covert, manipulative limit-testing, while overtly cooperating and trying to please.

Children who failed to form relationships at all were missing a major motivation to perform and learn. School would not be likely to be rewarding to such a child, and many socialization efforts will fail, as they rely on social reinforcements that are meaningless to this child. These children showed the precursors of sociopathy. The quality of the relationship formed also presented difficulties. All of the relationships described above interfered with the child's ability to learn and/or perform, because whichever affect was involved, the child was devoting too much energy to the interpersonal aspects of the situation, leaving too little for his/her own learning.

Self-Concept. It has been noted that most abused children suffer from low self-esteem and/or a negative self-image. The children dealt with this in various ways that interfered with their test performance and their ability to learn, as well as with their emotional growth.

1. Some children responded defensively, fighting the negative feelings. At least two ways of doing so were observed in these children, both of which were sometimes seen in the same children.
    a) Some children responded with denial; boasting about their intelligence and denying the existence of any problems. They often did not recognize failure and claimed success while doing poorly.
    b) Others responded with anger and hostility, called the test and/or examiner "stupid," and refused to do the tasks, expressing disdain toward the school or the testing.

    These types of responses interfered with performance and learning as the child's energy was devoted to fighting off a fear of failure, and bad feelings about himself rather than to doing his best on the test. Furthermore, by not recognizing failure, these children often did not learn from their mistakes. They also had a problematic adjustment to a negative self-concept; i.e., a denial of problems and/or anger and rejection of the expectations which they failed to meet.

2. Instead of fighting off the negative feelings, some children responded by accepting the image of themselves as stupid or worthless. Again, there were several ways in which the children were observed to respond to this, and more than one was sometimes seen in the same child.
    a) Some abused children set unrealistically high expectations for themselves and were extremely self-critical when they failed to meet them. They often showed a perfectionistic attitude toward their work--"unless it's perfect, it's worthless." Thus, they reinforced their negative self-concepts by not being perfect.
    b) Often there was a great deal of anxiety around performing. This seemed to be based on the expectation that they would fail and/or be criticized. In the overly self-critical children, this was often unrealistic, but for others it was based on a history of repeated failures, so that they had come to expect little of themselves and accepted a sense of low self-worth.
    c) Some children responded with an overt fear of failure, gave up easily, withdrew from the task and/or said "I can't," "I'm dumb," or "I never do things right." This often had the quality of saying "I've given up on myself," or "Don't expect anything from me--I'm too stupid." These were perhaps the most self-defeating children. It was as though they really had given up on themselves and no longer even tried to succeed.

It is obvious how these various self-critical ways of responding to a negative self-image would interfere with learning and performance. These children are likely to experience continued problems emotionally, as well as in cognitive areas, unless interventions are made to help the child develop a more positive self-concept.

Frustration Tolerance. Frequently, low frustration tolerance was noted in these children, but this too appeared in different forms, characteristic of the child's overall coping style.

1. One response in the child who was easily frustrated was to withdraw from the task, saying "I can't," "I don't know," "It's too hard," and giving up without much trying.

2. Another response seen was anger. The child may become angry at the examiner for asking the child to perform, he may throw or push away test materials, or refuse to do the task. This refusal differs from withdrawal in its affect. The child who withdraws may be anxious, fearful, or resigned to failure. The angry child may refuse with "I won't" instead of "I can't" or say that the test is stupid.

3. A third response to frustration that was noted in some children was regression. In the face of frustration, some children reverted to baby-talk, whining, whimpering, asking the tester to do it for them or engaging in silly behavior at a more immature level than their usual behavior.

Clearly, none of these methods of handling frustration was very adaptive. This was especially so since most of these abused children became frustrated more easily than average children. Their coping styles were self-defeating, and led to more failure, which led to more frustration, and so on, in a vicious cycle that could result in the child rejecting any potentially frustrating experiences. Clearly, this would lead to difficulty in school.

Attentional Difficulties. A number of attentional problems were observed in these children during testing administrations.

1. Distractibility due to external stimuli:
    a) High levels of physical activity--inability to sit still for very long.
    b) Hyperdistractibility--easily drawn from a task by other external stimulation. This included asking about, or playing with things other than appropriate test materials, asking other questions, or wanting to do other things.

2. Distractibility due to internal stimuli. Many of these children were preoccupied with emotional concerns, worries or fears that prevented them from attending to the task at hand.

3. Some children had difficulty attending to the task because they were preoccupied with the examiner rather than with the test. These children may have been those who were eager to please, or those who were hypervigilant due to a learned fear of interacting with adults.

Any of these styles of interacting make learning, as well as performing on tests, difficult and are likely to create problems in the school setting. This is particularly so for the hyperactive and angry children, since they are management problems for the teacher. However, the preoccupied, withdrawn child is equally in need of attention, as this too is a self-defeating style. It was obvious when testing these children that they had bigger things to worry about than the cognitive learning that their peers were more free to be involved in.

Impulse Control. These children tended to be at one extreme or another on a continuum of impulse control. There were children with very poor control and those who were over-controlled.

1. The child with poor impulse control had difficulty controlling:
   a) Motor behavior, activity--as with the hyperactive child.
   b) Angry impulses and aggressive behavior.
   c) Needy impulses, clinging, attention and affection seeking behavior.

   They often answered test items quickly, without much thought, as if they just wanted to get it over with.

2. The overly controlled child was usually the "eager to please" child. Frequently these children behaved like miniature adults, showing stereotyped "grown-up" behavior, and denying or suppressing their own childlike impulses, behaviors and emotions. The overly controlled children often restricted their verbal and motor test responses, perhaps out of the experience that such activity was often punished (often, throwing a bean bag seemed frightening to them.)

Once again, it was easy to see how the disruptive child with poor impulse control was likely to have trouble getting along academically and socially. The overly controlled child can be the one whose impulses remain unexpressed for years, and who has the potential to become highly explosive if the impulses ever become stronger than the rigid control.

Child's Response to Test Itself. Several difficulties in relating to the test itself were noted in these children.

1. Difficulties with physical test materials:
   a) Some children were noted to be fearful of touching the materials as called for (e.g. hitting xylophone, throwing bean bag at target). This interfered with their ability to perform tasks. These were over-controlled children.
   b) Other children were needy in terms of material gratification. They would ask to keep testing materials and/or attempt to sneak them into their pockets. These were sometimes the same children who seemed to have insatiable needs for affection.

2. Difficulties with verbal test materials. As noted in the data, these children generally performed better in non-verbal areas than verbal ones. Some of these children showed significant discomfort with verbal modes of expression and this obviously interfered with their performance on verbal tasks. It may even have affected the non-verbal tasks, since the directions were often given verbally. In part, this verbal difficulty was due to their language deficits, which may be due to their experience that speaking out is frequently punished.

Thus, in addition to relating to the examiner differently, the children being tested responded differently to the actual test materials. If their responses interfered with their ability to complete the task well, this hindered test performance.

Motivation and Performance Orientation. This section summarizes the effects of all of the previously described behavioral characteristics on the child's handling of the testing situation. Several overall orientations were observed:

1. True indifference to all aspects of the testing situation. This was found only in the child who had already rejected socially valued behavior and adults as sources of social support. Such children were not motivated to do their best on the test. While rare, this sort of child was of great concern, as he or she seemed already on the road to a sociopathic adjustment.

2. Other children appeared disinterested at the time of testing due to a preoccupation with emotional concerns. Except when this was severe, the child was likely to show concern over the test but may have been unable to maintain concentration, etc. This child's motivation was interefered with by more urgent concerns, such as family problems, specific problems in relating to one or both parents, or concerns about his/her own security and well being. Such children were of concern because of the effects this was likely to have on their mental and emotional growth.

3. Some children appeared disdainful or disinterested as a defense against their own fear of failure or sense of inadequacy. This was the child who was trying to overcome his/her own negative self-image by denying any problems when presented with them, or was angrily rejecting anything which confronted him with his difficulties. This was another type of child who was rejecting social values. He differed from the truly disinterested child in that this child rejected out of an urgent attempt to salvage his self-esteem. The emotional growth of such children was also of concern.

4. Another group of children was very interested in the testing situation, but was interested in aspects other than the desired one. That is, there were children whose motivation was extremely high, but was focused on the examiner, rather than on their own test performance. This included the children whose energy was devoted to pleasing the examiner and those who were intent on trying to get certain emotional needs met by the examiner. These children were motivated, but their energy was misdirected. Thus, they were likely to encounter academic and interpersonal problems because they were trying too hard, in the wrong ways, and in the wrong direction.

5. The child who had a self-image of incompetence and worthlessness seemed to withdraw interest and motivation from the test as soon as he/she had any difficulty. Often they set out with motivation, but lost it easily if they sensed failure was likely. Such children would have a hard time learning, since they would be afraid to risk anything. In severe instances, the child may have given up even before encountering the tasks, assuming that it could only be another failure experience. Here again, the emotional development of these children would be likely to be poor.

6. Finally, there was the child who was extremely motivated and attentive, but whose anxiety interfered with the ability to learn and/or to perform. Many of these children had unrealistically high expectations, were perfectionistic and highly self-critical. They kept trying, but could never satisfy their own expectations.

Some of these performance orientations were self-defeating, and led to chronic failure patterns. Such experience may well lead the child to resignedly give up socially valued behaviors and skills, or to give them up angrily. Others of these orientations, while also leading to patterns of failure experiences, seemed more likely to lead to significant inter- and intra-personal emotional difficulties.

In conclusion, there were two patterns that cut across specific categories of behavior to identify two general groups of children in this population:

1. Those children who were already very angry; acting out, aggressing, and beginning to reject social values and relationships with other people. Some children in this group had already begun to show sociopathic characteristics.

2. The other group of children were those who were still trying to succeed within the system. They were either feeling very badly about themselves and continuing to strive for perfection, or they were of the "eager to please" variety who were likely to be very manipulative in a covert manner. The former often showed signs of depression, while the latter were more concerned with their own behavior as a way to succeed, not through their own achievements, but by pleasing adults around them. Children of this latter sort often appeared to be very pleasant, but superficial.

A behavioral rating scale has been developed to measure the various behaviors described in this report. Completed by the examiner testing abused children, this will help to determine how well the assessment reflects their real cognitive and intellectual potential and also to make projections of the course of their future development. This scale is presented and discussed in Appendix XII.

Problems in the Cognitive Assessment of Abused Children

Abused children generally showed cognitive deficits when assessed by standardized tests of cognitive ability. However, the examiner and others involved with the child (social workers, houseparents, etc.) consistently felt that the childrens' test scores were not accurate estimates of their cognitive ability. Many children who appeared to be of average intelligence tested below average. Many who seemed particularly bright had average scores. It seems that standardized test scores generally underestimated the cognitive ability of the abused child. The question then becomes, what problems are involved in the cognitive assessment of these children that could account for the discrepancy between their scores and their observed greater ability? From observation, of the children tested through the Family Center, it seemed that there were a number of interrelated factors involved. All of these stemmed from the experience or environment of the abused child. For reasons discussed below, the environment of the abused child usually has had an adverse effect on the child's cognitive development so that his/her developmental level was often less than that which the child was capable of achieving. In addition to interfering with the child's development, or learning, the abusive environment affected the child in ways that made the standardized testing situation particularly difficult and interfered with his/her ability to perform up to his/her capability.

This section addresses two issues: 1) How the experience of the abused child interferes with his/her cognitive development and thus makes it impossible to determine what the true intellectual potential is, and

2) How their experiences make the testing situation particularly problematic for these children, thus making it difficult to accurately assess even their current level of cognitive functioning.

1) How the Abused Child's Experiences Interfere with his/her Cognitive Development. The most obvious impediment occurs when neglect or deprivation is present. The effects of early deprivation (emotional and/or stimulus deprivation) are well known to have serious effects on cognitive development. In such cases, the child does not receive the opportunities needed for normal learning. Even when neglect is not present, the abusive environment limits the child's opportunity to learn. The abused child lives in a world that is sometimes hostile and almost always unpredictable, particularly with respect to the behavior of the adults in it. Thus, the child's ability to perceive order in his/her world, and to understand causality is impeded. Furthermore, because the parents have such great power over the child, he/she must devote great amounts of attention and energy to the parent(s). That is, while other children are exploring many aspects of their world and learning how it operates, the abused child concentrates on trying to learn how only one aspect of it operates--the parent(s). Frequently these children display great skill in this area (a testimony to their cognitive ability), but at the expense of their learning in other areas normally expected of children their age. Thus, their cognitive development is interfered with by their preoccupation with more important issues--survival, safety, and security. The effects of this were reflected in the behavioral observations presented earlier. The hypervigilant child, preoccupied with pleasing the examiner and the fearful or anxious child all exhibited the effects of the abusive environment.

Another way in which the abusive environment may interfere with cognitive development is by discouraging exploration of the physical and social environment. These children seem to learn, at an early age, that activity is likely to lead to trouble, and that it is safer to stay quiet and leave things alone. This is true of physical activity and verbal activity, thus interfering with the development of language skills,as well as other skills. In the project's children, this was reflected in the behavioral observation of the difficulties some of the children had with manipulating test materials, and in the observation of their discomfort with verbal expression. This latter observation was further substantiated by their low test scores in the verbal area.

2) How the Child's Experience with an Abusive Environment Interferes with Performance in the Testing Situation. Abusive parents have been frequently observed to hold unrealistically high expectations of their children, and to demand of the children that they meet them. Thus, while the child finds that self-motivated activity may be dangerous, it is necessary to be very active in meeting parental demands. Because the expectations are unrealistic, however, it is unlikely that the child will succeed in meeting them, and to fail is also dangerous. Therefore, while performance is necessary, imperfect performance is dangerous. The effects of this predicament were also reflected in the behavorial observations of these children during the testing session. The testing situation was one in which an adult called upon the child to perform. The child's experience led him/her to perceive this as dangerous, because perfect performance was likely to be expected. The result was intense fear of failure, high levels of anxiety, and/or perfectionistic expectations

by the child of himself/herself. The various ways in which the children coped with this are noted in the behavioral observations section. Few of these attempts to cope were adaptive. Instead, they interfered with the child's ability to show what he/she knew.

Another closely related problem inherent in the testing situation itself, was the child's experience that adults have been unpredictable and dangerous. Thus, when the child was confronted with a new adult to interact with, he/she frequently devoted a great deal of attention to observing the examiner and trying to figure out what was safe, and was likely to please. This hypervigilance took up the energy and attention the child should have been devoting to the test items, thus interfering with performance. The effect on some children was a withdrawal from and/or anger towards all adults. This obviously interfered with test performance due to problems in relating to the examiner and in being motivated to perform. A frequently noted characteristic of these children was low frustration tolerance. Because high levels of frustration were inherent in the testing situation, most abused children had difficulty doing their best.

In general, the personality development of abused children reflected their early experiences. While the results differed from child to child, certain common factors such as poor self-esteem and low frustration tolerance almost always interfered both with the child's willingness to take the risks involved in learning new things, and in demonstrating what they knew in a "dangerous" setting. With this, in addition to all of the interferences mentioned above, it was impossible to accurately assess the cognitive potential of the abused child (i.e. what he or she could accomplish under more favorable conditions). It also was very difficult to assess accurately the child's achieved level of cognitive functioning since, the method for doing so (i.e. a standardized test of cognitive development) was particularly problematic for these children. In the following section, recommendations are offered concerning how to minimize these difficulties.

Recommendations

This section is intended to make suggestions to others who will be testing abused children, based on the experience of testing the Family Center children. It will include suggestions for modifying the testing situation to be less problematic for these children, when and where to test the children, what to look for, and how to assess the degree of interference their behavior poses. A scale for measuring behavioral problems has been developed out of the experience of testing these children and is presented in Appendix XIII.

Because abused children are likely to reach diagnostic and/or treatment facilities at a time of crisis or trauma, it is important to be careful about when the testing is done. No individuals can do their best when they are in the midst of dealing with an emotional and physical trauma. Therefore, to maximize the accuracy of test results, it is best to postpone testing until their child's life is relatively stable (e.g., after they are returned home, or adjusted to a new home, etc.) rather than testing them at the time of initial contact.

Where the child is tested is also an important consideration. Due to their experiences, these children are often fearful of authorities whom they fear will separate them from their parents or foster parents. Their lives often have included enough instability and interference from external agencies that they are highly suspicious of strangers. Therefore, it is best to test these children in familiar surroundings, such as their school, or their home if a suitable setting is available. Another important consideration is the room used. Because so many of these children show high levels of distractibility, physical activity, and/or poor behavioral control, it is especially important to use a room in which stimuli other than test materials are kept to a minimum.

As discussed in the previous section, the standardized testing situation poses particular problems for abused children. Thus, constructing a situation which will permit these children to do their best, thereby providing a better estimate of their level of cognitive functioning, requires modifying the standardized procedures. This is of necessity a trade-off situation. In order to permit a more accurate assessment of the abused child, some of the reliability that depends on rigorous adherence to standardized procedures must be sacrificed. If modifications are made carefully and creatively, the increased reliability of the test results (in terms of how well they reflect the child's actual level of cognitive functioning) seems well worth some small loss of comparability to others due to the modifications made in the procedure.

These modifications are aimed at making the testing situation less threatening, thereby minimizing the maladaptive defensive coping styles with which abused children respond. The examiner should take care to relate to the child in a warm and supportive manner. Offering the child positive reinforcement for his/her efforts usually helps a great deal. For most children, social reinforcers such as smiles and verbal praise of their efforts are sufficient. Some may respond well to physical responses such as a touch on the shoulder or a hug, but the examiner needs to be careful with this because, while some abused children are very needy and demanding of physical affection, others are quite wary. Empathizing with the child's difficulty and reflecting their feelings about it has proven to be very helpful, with both younger and older children.

To help minimize the frustration that is inherent in the test, the examiner might add an easy item (not from the actual test) after the child has struggled with a series of difficult items. In adding these, it is essential that while the examiner supports and praises the children he/she does not offer anything that will actually help them solve an item or following items.

To hold the attention of the distractible child, one might give the child short breaks between subtests to permit the child to explore other things or engage in other activities. With uncooperative children a "contract" or "promise" can often be worked out where the tester will allow the child to engage in an activity of his/her choice in exchange for completing the required tasks.

Occasionally it may be necessary to re-order the subtests for a child who has difficulty controlling his/her own behavior. If tests require gross motor activity, it may be wise to leave those until last; otherwise, the child may be unable to calm down and return to other tasks. Similarly, for the child who is unable to stay with verbal tasks for very long, it may be helpful to intersperse those with some of the performance or motor tasks where possible. These changes in subtest order should also be done thoughtfully, and only when necessary to insure test completion.

Abused children often show a great deal of variability across different skills. Their test results are an average that is often composed of very different scores in different areas. While testing these children, it is important to be aware of their various areas of strengths and weaknesses. They most often show greater ability in non-verbal areas than in verbal ones. Often their performance is better on reasoning tasks than on tasks which call for learned information. They frequently do poorly on tests which are affected by anxiety. They often do well on tasks requiring attention to detail or to social awareness.

Because neurological damage is not infrequent in abused children, any signs of perceptual, motor, or visual-motor problems should be carefully noted. It is important to learn enough about the child's history to help determine whether experiential deficits might account for cognitive deficits in any particular area (e.g. motor, verbal expression, etc.).

In order to help the examiner assess the degree to which the child's behavior or defensive style is interfacing with his/her test performance a Behavioral Rating scale based on the Family Center experience testing abused children has been developed. This tool is a first step to be built upon by others as they learn more about this area. It has not been used in testing the abused children involved in this project, as an observational base was necessary in order to construct the scale. Thus, this scale represents only a first step towards meaningful interpretation of test results for abused children. It is hoped that the scale will not only measure behavior when the child is initially tested, but that it can also be used to measure changes in test behavior as a function of time and/or treatment. As far as is known, there is no other scale available which attempts to aid the tester in interpreting a child's test results in terms of behavioral interference.

In Appendix XIII is a copy of the Behavioral-Reaction Rating Scale for IQ tests and an explanation of each item, its meaning and how to score it. This explanation should be used concurrently with the rating scale itself.

Difficulties in Doing Research in this Setting

Data Collection

In a setting which basically provides clinical treatment, there are always problems when the clinical management needs of a case conflict with research requirements.

This was experienced in this project around the initial data collection. Workers believed that asking for data from the parents at the beginning of treatment might jeopardize the difficult task of establishing a relationship with their clients. It was also difficult to collect data during a crisis period for the client, a not infrequent occurrence with this population.

There were particular difficulties in collecting test-retest data on children's IQ tests. This population of children was extremely mobile. In several cases, either the family moved, the child went to live with another parent or resident outside the Denver area, or went into residential treatment elsewhere. This resulted in the numbers of children retested in the treatment, no treatment and crisis nursery groups being too small for reliable analyses between groups. In addition, the variability of scores observed in the small group of children in this project were typical of those observed in larger population studies in the abuse field. The change scores had enormous variability within groups. With small groups and extreme variances in scores, significance testing became meaningless.

A chronic problem for projects of this sort is motivating staff and data sources to complete the forms. This project had less than the usual amount of difficulty in this area, but parents whose cases had been closed sometimes refused to allow themselves and/or their children to be retested.

Control Group

The largest problem which confronted the research effort was the collection of control group data. Ethical considerations of treatment made random assignment to a no treatment control group impossible. At best, a control group with minimal treatment could have been obtained from the department of social services groups. Project staff was working to capacity and could not have been expected to collect data on control groups. The department of social services workers were overloaded and were unable to provide control group referrals. Although they were asked for, it was not suprising that no control group referrals were forthcoming. The effects of the lack of control groups upon data interpretation is particularly noticeable when using forms with no standardized norms. This problem affected all project data, with the exception of IQ tests and self-esteem measurements.

Ultimately, the research staff of any such project must be responsible for control group selection and data collection. In this project, time and financial resources were not sufficient to perform this task.

Data Management

The task of organizing and keypunching the relevant data in a retrievable form was enormous in this project. A full-time data manager could have been useful to make sure that all forms were properly coded. The missing data problem in this project, which did not give sufficient attention to data management, was of greater proportions than could be accounted for by prior reasons given for missing data.

Recommendations for Other Settings

The most important recommendation involves planning for data collection and all analyses desired well in advance of any data keypunching. This would help to insure that cards will be complete and all needed data easily retrievable. It is extremely important to include sufficient funds in the budget to hire an experienced research psychologist on a full time basis; one who knows all aspects of research, from design to data collection. At least one full-time clerical assistant to the researcher would be needed. Because of the previously discussed advantages to this project of having a research team present as part of the project's staff, it is recommended that future projects of this sort each have their own research team. Organizational consulting from an independent organization may be useful in assuring that all projects collect comparable data. However, the responsibility for collecting, utilizing and analyzing the data can best be done at the local level. If a master analysis comparison across projects is needed, the consulting firm can reenter at that point. It was gratifying to see the attitude of the project staff change from one of concern about being overburdened with research demands at the beginning, to willing cooperation and even enthusiasm about research goals during the life of this project. Such a change is not likely to occur in projects responsible only to remote research organizations.

The forms used in this project have yielded usable cluster structures, as outlined in this report. This will make the task of using any of these questionnaires easier and less expensive for any future projects. The major contribution of this project's research has been the development of forms for measuring behavior in different settings, moods, effect of behavior on cognitive performance, marital problems and treatment outcome. These forms should be made widely available and further use encouraged.

Conclusions and Recommendations for Further Research

Further research is clearly needed to study the impact of the abusive environment on cognitive development, and the effects of various therapeutic interventions on further cognitive development. In particular, larger numbers of children need to be studied in order to have more findings, which can be generalized, and in order to be able to make statistical comparisons of the effects of various interventions. Longitudinal studies are badly needed as well in order to determine the long range effects of treatment efforts. It is particularly recommended that more cognitively oriented treatment efforts be made at some point with abused children, particularly in the area of remediating verbal deficiencies and academic learning deficits. It may take longer than the time allotted in the Crisis Nursery or Therapeutic Day Care Center to produce change based on the cognitive strategies employed by the project for verbal remediation. It is also possible that the most effective intervention strategies were not used. It is recommended that projects providing treatment to abused children employ an early childhood education specialist to maximize cognitive intervention.

It is also obvious that cognitive intervention can only be successful if emotional stabilization is also present. Yet, if these children improve emotionally, they are still so far behind in academic and verbal skills that they will not be able to succeed without remediation.

As far as behavioral changes in the children are concerned, it would be extremely interesting to follow the children who became more frightened, scared or acting out during treatment to see if these feelings are resolved with further treatment, so that adjustment ratings continue to improve. The relatively small gain in children's progress ratings over the time of their involvement in the project is of some concern.

Children's self-esteem scores did improve with treatment, and it would be of great interest to see if those gains are maintained after treatment.

There were remarkably few differences between boys' and girls' intellectual functioning and behavior in this study. If this lack of difference is considered against the usual differences found in boys and girls of this age, questions are raised. It is usual for boys to have many more problems than girls up until adolescence. It is usual for girls to do better than boys in academic learning and verbal functioning in the age range of children served by the project. Questions about whether being raised in an abusive environment has a greater impact on the development of girls than it does on boys must be raised.

It is clear from the data that actually abused and potentially abused children did not differ in cognitive functioning after the age of two and one-half. There were also no behavioral differences found as a function of actual versus potential abuse. Severely and potentially abused children were more similar to each other in functioning than either were to the mildly or emotionally abused group, which seemed to have the most disturbed functioning. The crucial variable affecting functioning seems to be a combination of length of time spent living in a disrupted environment and the degree of disruption in the environment.

This finding needs further corroboration and elaboration, as it is of the most crucial importance to program planners. The largest proportion of available resources in most departments of social services is now going to actually abused children, and not potentially or emotionally abused children. In fact, in many departments of social services, treatment services are limited to those families in which documented physical abuse has occurred, so that emotionally and potentially abused children are not treated. While the physically abused children who come to a department of social service's attention must surely be helped, they are most likely no worse off developmentally than the emotionally or potentially abused children in the department's county. Something must be done for these children and their families also.

To no one's surprise, the younger project children were doing better intellectually than the older children, particularly than those older children in severely disrupted environments. Obviously, intervention in families, while the children are still young enough that stabilization of their environments will spare them the development of future problems, is recommended. This research would seem to show that before the child is two and one-half years of age is the optimal time to protect him or her from serious developmental and cognitive problems. Some behavior and attachment problems were already observable between nine and twelve months of age.

It is difficult to reach a conclusion about the general lack of difference in improvement between those children who had direct services provided and those children whose parents only received treatment. Data was available on too small a number of children in each group in many cases. However, it is most likely true that a combination of two problems was responsible for the lack of differential gain. There was most likely a combination of not using a truly effective intervention strategy for some of the children, and having insufficient treatment time to effect a change in children who were so developmentally and emotionally deficit. The latency age group was not seen as effective, for the most part, by the therapists. Crisis Nursery intervention was effective in many ways, but there were concerns about its short term nature and the overwhelming impact of the environment to which the child was returned on his/her future development. Therapeutic Day Care was also seen as needing longer time with the child before effectiveness would be optimal. At the end of the project, the staff recommended exploration of more structured intervention strategies with children, such as Spivak and Shure's cognitive approach to teaching social adjustment to children. A grant which includes evaluating the impact of such a strategy has been submitted. Such an approach has the dual advantage of teaching cognitive problem solving techniques, as well as social adjustment skills.

Serious consideration must be given the problem of dealing with abusive fathers. Although parent-child interactions improved after treatment, fathers did not improve as much as mothers, and mothers were doing better than fathers at the beginning of treatment. In general, the project's male clients were more seriously disturbed in functioning and improved less than the female clients. Demonstrations aimed at development strategies for involving and improving the functioning of actual or potentially abusing males are badly needed. In general, there was very little difference in the functioning of actual versus potentially abusing parents. Both groups improved equally with treatment. This finding parallels the results of research in the children. A good case can be made for the necessity of intervening in potentially, as well as actually, abusing families.

Effective strategies for reaching the youngest and oldest age groups of parents are also needed. The staff recommended the exploration of more structured intervention techniques, such as those of Patterson and Reid, with these families.

Self-esteem in the parents in treatment was not modified as much by their treatment as was the self-esteem of the children. This finding recommends the treating of children as well as parents.

The results of the study of the marital adjustment of project clients were intriguing. Denial of problems at the beginning of treatment was common and may have reflected either lack of awareness of problems or lack of trust in the worker to reveal problems so early. Wives were more dissatisfied with their marriages than husbands were, or at least they were more willing to admit it. They judged the communication in their marriages to be worse, their closeness to spouse as less, and thought their spouse was not as good a person, in comparison to their husbands' judgment. The wives had higher expectations for closeness in a marriage and were less tolerant of independent action in their spouses. Thus, their frustration level in the marriage was bound to be higher. More research is needed on marriages in abusive families, particularly with reference to the preliminary finding that marital disruption may be greater in the homes of the mildly-emotionally abused and failure to thrive group of children. This was the group whose cognitive and behavioral functioning seemed the most affected of all children. The interaction effects between the problems of the children and the problems of their parents need further research.

It is hoped that the evaluation and assessment forms for children, parents and parent-child interaction developed by the Family Center project can be of use in future research efforts.

ADVISORY BOARD

Vicki Van Dyke and Margaret A. Nicholson

Introduction

From the inception of the Family Center, it was planned to organize a community relations board consisting of lay group representatives, consumers, and other interested people. The goal of such a board was to increase community involvement in the planning and development of programs at the Family Center. The specific objectives were: (1) to increase the total number and kinds of groups to which the speaker's bureau would make presentations; (2) to assist in the presentations of the speaker's bureau; (3) to assist in the development of a volunteer program; and (4) to assist in exploring funding resources for the continuation of the various program elements.

Development and Implementation of the Advisory Board

The Family Center Advisory Board was organized at the end of the first project year. The project coordinator held meetings with the project staff and the grantee agency administrators to solicit names of lay and professional community people who would be helpful to the project. In a result of these meetings it was decided that there would be consumers of services in the area of abuse, young people, lay, and professional people who had exhibited an interest in the problems of child abuse and neglect. Many individuals were contacted. As a result the advisory board consisted of representatives from Parents Anonymous, a local attorney, school representatives, the chairperson of the Metropolitan Child Protection Council, a youth from the local high school, a social worker from one of the school districts, a local school teacher, and several lay members.

The board met and the project coordinator reviewed the goals and objectives as they were presented in the initial grant proposal, established a routine meeting time, and began the board's orientation to their work with the Family Center. During the board's orientation meetings, the Family Center staff presented program information identifying the various program goals and objectives. In addition, the board met with the grantee agency and administration and participated in a training session for legislative involvement.

Following these meetings the board reviewed their goals and objectives. This resulted in alterating the initial objectives. Because the Multidisciplinary Review Team was also acting in a quasi-advisory manner to the project, this advisory board wanted to have a role different from that team and yet maximize their own input into the project. Thus they decided not to provide advice on program development or policy issues, but to concentrate their efforts on the community aspect of the project.

The advisory board planned to assist with public speaking, to refer people as volunteers, and to assist with exploring funding resources.

The Family Center Advisory Board met on a monthly basis. These meetings usually had an agenda which had been planned the previous month. Additional issues were discussed if they arose during the month. The meetings were an opportunity for Family Center staff, specifically the project director and coordinator, to communicate project goals, plans, and progress. Through this process, ideas and reactions were encouraged.

At the same time, specific activities for board members were explored and planned. Since one of the objectives was to assist in exploring funding resources, a training session was planned to more thoroughly acquaint the board with the fiscal problems of the project and the program components. Another training session was scheduled in which a lobbyist for child advocacy helped board members to identify key legislators to approach regarding funding and to determine the most effective process for approaching them.

In April, 1976, when the Family Center learned of a funding cutback which would have resulted in the premature closure of the project, advisory board members were closely involved and were involved in initiating a letter writing campaign which resulted in a change in the federal government decision. They accomplished this using the techniques they had discussed in the training session.

Issues

Membership on the advisory board was an important issue. The composition of the team was determined in part by the philosophy of the project staff, by the availability and interest of certain people, and by the goals and objectives of the board. On the other hand, the members also determined the focus and direction of the board to a great extent. Although attempts were made to assure that members represented a broad spectrum of the community, this was difficult to accomplish due to the time limitation of potential members. At times, bringing together people with such diverse backgrounds resulted in their having difficulties working together as a group.

Initially attendance was good at the advisory board meetings, but became an increasing problem as the project continued. Some of the factors which contributed to this were: 1) some members were overextended in the time commitments they had; 2) the difficulty in choosing a mutually convenient time; 3) differences in individual's comfort with certain tasks; and 4) a lack of clarity about the function and purpose of the advisory baord.

Part of the confusion about function was inherent in the fact that an advisory board functions quite differently in a public agency than in a private volunteer agency. In a private agency, advisory boards review and recommend policy, program development, personnel rules, etc. Most of these issues, in a public agency, are predetermined by a higher authority and are not easily subject to change. In regard to child abuse, many advisory board members felt they did not have the expertise to advise staff regarding program issues. In addition, an advisory board for a grant project adds a further dimension which can result in confused responsibilities and authority. The grantee agency already had an advisory board, and a natural outcome was confusion as to roles and function.

Outcomes

Despite these difficulties, the Family Center Advisory Board made important contributions. They were very instrumental in a letter writing campaign requesting a reversal of the decision to cut the Family Center budget. They were involved in the speaker's bureau, and as a partial result many community leaders are better educated about the problems of child abuse. In addition, it is anticipated that some members of the Family Center Advisory Board may lend their expertise and share their experiences as advisory board members to a proposed Law Enforcement Assistance Administration Grant if it is funded. This grant project will be treating abused children and families in an effort to prevent juvenile delinquency.

One advisory board member was extremely helpful in the Crisis Nursery Program. She encouraged her art students to volunteer and become involved with the children. These students helped the children with painting and art work and attempted to increase the child's use of art to express their feelings. Another contribution these students made to the nursery was painting three oils which enhanced the environment of the nursery.

Chapter Fourteen

TRANSITION OF THE PROJECT'S PROGRAMS

Margaret A. Nicholson

Introduction

The original authors of the grant proposal and the grantee agency, the Adams County Department of Social Services anticipated the project would continue after the federal funding ended in 1977. The grantee agency had verbally committed twenty-five percent funding the first year, fifty percent the second, seventy five percent the third and in the fourth year it planned to continue the total effort. However, state and local monies were not made available to implement this plan. Thus, the grantee agency's fiscal contribution varied from twenty-five to thirty four percent over the three years of the project. In addition, the state Director of the Colorado Department of Social Services assisted in the project's operation with some Title XX monies in the second and third year.

Funding is an essential component of an operation as large as this project, but support from the community and it's agencies is another. Over the three years of the project, $202,387 was offered by the agencies of Adams County as an in kind and cash outlay contribution to the project's programs. Additionally, the University of Denver, Speech and Audiology Department contributed their expertise in evaluation and treatment of the Crisis Nursery children. Without this support such services may not have been available to the children.

As was mentioned earlier, the Westminster Kiwanis also provided a tremendous amount of labor and materials to the project. These men and their families worker with the staff in rennovating the project facility, which resulted in a savings of approximately $10,000.

Many other individuals and agencies were supportive to the project. There are too many to enumerate in this text, but their support will always be remembered.

Transition of the Project's Programs

The Family Center Project has ended but some programs are being continued by the staff of the grantee agency, the Adams County Department of Social Services. From the beginning of the project, the project director and staff started planning for the transition of these programs. However, in January, 1977, the director of the grantee agency left his position and an acting director was appointed for three months. During the interim appointment, the acting director did not think it was appropriate to make program decisions regarding the project. He believed the directorship of the agency needed to be involved. Thus, major decisions regarding the project's programs were delayed until March, 1977, when a full time director was appointed.

At that time, the grantee agency director, protective services supervisors, the project director, and staff began planning meetings to effect the transition. The grantee and project staff had one half day of meetings to assess the department's program needs and to determine priorities regarding what project programs would be transferred and implemented in the department. As a result of these meetings, the program areas to be continued were designated and plans for transferring them were made. The following is a discussion of the program areas and the plan for continuing them.

Protective Services Resource Coordinator

The grantee agency had been providing the funds for one social worker position on the project. It was suggested that this position could be used to coordinate the Lay Therapy, School Referral, and Therapeutic Day Care Programs developed through the project. This position was given to a protective service worker who begain in June, 1977.

Lay Therapy

This program is being continued through a contractual arrangement between the lay therapists and the grantee agency. All six of the Family Center's lay therapists are continuing in the program. The grantee agency is planning to expand this program in the future.

Therapeutic Day Care

The resource coordinator has assumed the responsibility of continuing this program in the grantee agency. The one therapeutic day care home, that was operating, closed at the termination of the project. The day care mother was seeking employment in the child abuse field in another capacity. Thus, this program will be continued as the resource coordinator selects other day care homes, trains the mothers, and implements the design created through the project.

School Referral Program

This was one of the high priority programs to be continued by the grantee agency. It is being continued under the direction of the resource coordinator and six protective service staff social workers. This staff, with assistance from the project liaisons, transferred and assumed the liaison roles. Each new school liaison met with the key personnel in his/her district. The public school districts wrote letters of support to the grantee agency administration to insure continuing this program.

Role of the Nurse

Another project position that is continuing in the department of social services is the nurse. The value and contribution of this type of expertise in the child abuse service program was recognized and this position was given a very high priority. The project nurse assisted in the recruitment screening, and employing of a nurse who would continue meeting her responsibilities after she left the community.

Public Awareness and Professional Education

This program was based upon the work of Adams County agency professionals prior to the beginning of the project. These professionals will continue their efforts in helping the community to be aware and educating them about the needs of abusive families. The divisional head of protective services (an open position that is to be filled soon), will be responsible for the coordination of the department's involvement in this effort.

Multidisciplinary Review Team

This program will continue. In fact, each county department of social services in Colorado that has 50 or more reported cases of child abuse and neglect is required by law to have a child protection team.

Crisis Nursery

This program was ended in April, 1977, when the project's houseparents resigned and left for graduate school. The nursery has not been reopened. However, the grantee agency has stored all of the equipment and property and is anticipating reopening it. The plan is for the grantee agency to enter into a purchase of service agreement with a private, United Way Agency, which will staff and operate the nursery program. Plans indicate that the nursery will reopen in the Fall, 1977.

Therapeutic Foster Care

This program has been transferred from the project to the foster care placement unit in the Adams County Department of Social Services. This unit is planning to continue this program, but with a fewer number of contacts and more limited consultation with the foster parents.

Training of Foster and Day Care Parents

This program area was implemented in the second year of the project. Following this initial training, provided through project funds, the responsibility for continued training was assumed by the grantee agency. A special unit was designed to provide for placements of children, recruitment, licensing, and training of foster parents.

Crisis Response Intake

The county department of social services in Colorado has the responsibility for providing immediate intake services to abusive families. Although the project initially provided for all intake services, this responsibility was shared with the grantee over the life of the project. All child abuse intake services will continue to be provided by the Adams County Department of Social Services. Every referral received by the department will be assessed and that assessment will be reviewed by the Multidisciplinary Review Team.

Tratment of Adults

The treatment of abusive and potentially abusive adults through the project ended in May, 1977. However, abusive parents will continue to be treated through the grantee agency and other agencies in the county. The main void created as a result of the project's ending is the intensive treatment offered by the project staff to some of the parents. Also, the groups used with adults will not be continuing immediately.

Because of the worker's high caseloads, continued increase in reporting, and insufficient funds for staff, the department has implemented a new policy. The department will not treat non-abusive or potentially abusive adults unless they contract for such treatment. This new policy will seriously affect the preventive approach in child abuse that the project and grants attempted to develop.

Treatment of Children

The treatment of children offered by the project has ended. However, prior to the close of the project, the staff wrote a grant proposal and submitted it to Law Enforcement Assistance Administration to establish a treatment team for abused children. This team would be multidisciplinary and would treat children ranging in age from four to fourteen. The method of treatment would be based upon Spivak and Shure's work. Funding for this proposal has not been decided, but the grantee is anticipating that funds will be made available.

As a second alternative, the director of the grantee agency has stated that, if the LEAA funds are not forthcoming, he would fund one of the former project staff, now working with him, as a child therapist. This social worker would continue to treat children, attempt to develop other children's programs, and assist in the development of reopening the Crisis Nursery.

When communities receive special grants or projects it usually is an experience of enhancing a service program area. However, too often the community also feels a tremendous void and disappointment when the special funding terminates and the programs end. Both of these situations occurred in Adams County. The project and grantee agency worked closely together to attempt to enhance this service area. The child abuse service program was greatly improved and expanded by the Family Center Project. However, the community also felt a sense of loss when the project closed and some of the programs ended. This feeling was not as intense as it could have been had the grantee agency not assumed some of the programs created through the project staffs' efforts. Many of the staff believe that the Adams County Department of Social Services will attempt to continue to enhance their protective service system. Much of their success will be dependent upon their funding resources, the county, state, and federal governments. Another contributing factor to the success of the program will be the continued level and intensity of the community's involvement.

The contents of this manuscript have been written by the staff to assist other professionals in the field of child abuse. The project staff thought that the most accurate description of the service areas could be offered by the individuals actually delivering the service. Thus, these people committed themselves to the very disciplined task of writing, in order to be as helpful as possible.

The editors and authors anticipate that others in the field will use the experiences identified in this manuscript and expand upon them. From the Family Center project's experience, more treatment programs for abused children certainly need to be developed and research needs to be a part of that effort.

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    B. The Family Center
    C. Some Dynamics of Child Abuse
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APPENDIX I

ADAMS COUNTY SCHOOL DISTRICT 14

MEMORANDUM

TO: All Building Principals and School Health Personnel

FROM: Pat Brown, Coordinator, School Health Services

DATE: September 19, 1974

TOPIC: Child Abuse Procedure

I. Building Procedure

- A. Suspected abuse will be referred immediately and initially to the building principal.
- B. Principal notify school nurse.
- C. School nurse will:
  - 1. Contact person making report
  - 2. Gather information:
    - a. How person became aware of the alleged abuse.
    - b. What the student volunteered related to the incident.
    - c. Any known previous history or suspicions of abuse.
    - d. Any known related problems with siblings.
  - 3. Fill out form CWS-59 (State Registry of Child Protection (Child Abuse Report) with the referrer.
  - 4. If necessary and feasible meet with the student to assess his/her condition.
- D. Based on data gathered, the principal and school nurse will determine:
  - 1. If suspected abuse is present:
    - a. The nurse will make immediate contact with the Social Services Department or the Family Learning Center dealing with child abuse.
    - b. The nurse will remain in contact with the person who is handling the referral.
  - 2. If it is determined abuse is not present:
    - a. The nurse and principal will document the incident on the school health card.

PB:ma

ROLE OF CHILD PROTECTIVE SERVICES

The presence of one or more of these characteristics should *arouse a teacher's concern* for the child's welfare. Whether there is true need for protection, however, is a determination which the protective services program will make after it has explored the situation. But, Child Protective Services cannot make such an exploration unless, and until, a person in contact with the child reports the circumstances pointing to the possible need for protection.

Teachers, and other school personnel, who report cases of suspected child neglect or abuse will rarely, if ever, get involved beyond the initial report itself. Protective services will develop the facts in each case and will diagnose the type and quality of service needed to rehabilitate the home and to reduce the neglect. It offers its special brand of social services to help parents become more responsible.

WHY OF NEGLECT AND ABUSE

Neglect and abuse of children is rarely willful or deliberate. It usually results from the inadequacy or incapacity of parents to live up to parental roles. Basically, most parents want to be good parents. It is the function and purpose of child protective services to give help to neglecting parents so that they may become more adequate and their functioning more acceptable.

A SCHOOL RESPONSIBILITY

Because schools are concerned with the whole child, seeking help for the child in trouble is quite compatible with educational objectives. The emotional impact of serious neglect and abuse often sets up blocks which inhibit and create learning disabilities for the child victim.

HOW MAY YOUR SCHOOL HELP?

If you identify a child who needs protection because of neglect or abuse your school should telephone and report the conditions to your local Child Protective program. This service is usually provided by the public state or county services to families and children.

IN YOUR AREA YOU MAY CONTACT

For additional information and a list of published materials on Child Protective Services please write to:

The American Humane Association
Children's Division
P. O. Box 1266
Denver, Colorado 80201

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GUIDELINES FOR SCHOOLS

Teachers
Nurses
Counselors
Administrators

AMERICA'S CHILDREN

TO HELP PROTECT
NEGLECTED AND ABUSED
CHILDREN

THE ALERT TEACHER

If teachers are alert to the signs and symptoms which point to the possibility of neglect or abuse they can take the first step to bring help to children whose needs are not being met at home. That first step is to invoke the community's child protective services on behalf of the troubled child.

The protective program is charged with responsibility for bringing services to neglected and abused children and their neglecting parents. It is a non-punitive, helping, skilled social service. Its focus is on seeking to stabilize family life, on enhancing parental capacity for good child care and on maintaining family intactness where possible.

CHILDREN IN TROUBLED FAMILIES

Teachers come into frequent contact with children who are physically or emotionally neglected or who are victims of physical or sexual abuse. Such troubled children may be found in families at any economic level or of any social status in the community. This is so because the motivating factors for child neglect or abuse may afflict any family. Common, underlying factors are emotional immaturity of parents, marital friction, alcoholism, drug usage, emotional disturbance or psychosis. These are families with problems, families under stress and, sometimes, families in crisis.

IMPORTANCE OF EARLY CASEFINDING

If children are identified when they show the earliest impact of their families' troubles, help can be made available at a stage when their problems can be more readily resolved. Too often referrals to protective services are not made until the conditions of neglect or abuse become acute and intolerable. Such referrals may come too late to salvage the home.

Here are some of the things to look for:

INDICATORS OF A CHILD'S NEED FOR PROTECTION

THE CHILD'S BEHAVIOR

- Is the child aggressive, disruptive, destructive? Such a child may be acting out of need to secure attention. He may be shouting for help. His behavior may reflect a hostile or emotionally destructive climate at home, or he may be imitating destructive parental behavior.
- Is the child shy, withdrawn, passive or overly compliant? This child may be as emotionally damaged as the aggressive child. He has internalized his problem; his cry for help is a whisper instead of a shout. He may be inattentive; he may daydream; he may be out of touch with reality.
- Is the child an habitual truant – chronically late or tardy? Is he frequently absent for flimsy reasons and lame excuses? This behavior points to problems of adjustment – problems at home, in school, within the child, or in combination.
- Does the child come to school much too early? Does he loiter and hang around after school is dismissed? This child may be seeking to escape from home – he may lack normal satisfactions at home. On the other hand, he may be "pushed out" in the morning and has no place to go after school because there is no one to supervise or care for him.

THE CHILD'S APPEARANCE

- Is the child inadequately dressed for the weather? Is his clothing torn, tattered or unwashed? Is the child not clean; is he unbathed? Do other children refuse to sit next to him because he smells? These are all signs of physical neglect, a condition not related to poverty. It reflects a breakdown in household management and in concern for the child.
- Is the child undernourished? Is he coming to school without breakfast, does he go without lunch? Again, this is often a problem unrelated to poverty.
- Is the child always tired? Does he sleep in class? Is he lethargic or listless? Such conditions are symptomatic of parental failure to regulate the child's routines, or of family problems which disrupt family routines.
- Is the child in need of medical attention? Does he need glasses or dental work?
- Does the child bear bruises, welts and contusions? Is he injured frequently? Does he complain of beatings or other maltreatment? Is there reason to suspect physical or sexual abuse?

PARENTAL ATTITUDES

- Are the parents aggressive or abusive when approached about problems concerning their child?
- Are they apathetic or unresponsive?
- Is parental behavior, as observed by school personnel, or as related by the child, bizarre and strange?
- Do the parents show little concern about the child? Do they fail to show interest in what he is doing? Do they fail to participate in school activities or to permit the child to participate?

APPENDIX II - B

THE FAMILY CENTER

4195 WEST 72ND AVENUE
WESTMINSTER, COLORADO 80030
P.O. BOX 669
(303) 426-0976

BACKGROUND AND SPONSORSHIP

The project idea was created by several agencies serving the Adams County area. These agencies included the Adams County Department of Social Services, The Adams County Community Mental Health Center, Tri-County Health Department, and the Adams County Juvenile Court. These agencies represented the core group of persons involved in the prevention, detection, and treatment of child neglect and abuse cases. Emphasis was placed on demonstrating a community-based, coordinated approach to education, identification, and treatment resources related to child neglect and abuse. All of these components were included in the initial grant request which was submitted to the U.S. Department of Health, Education, and Welfare and was subsequently funded by two subdivisions of that agency, the Office of Child Development and the Division of Social and Rehabilitation Services. Funding was granted for a three-year period beginning May of 1974.

STAFFING

The staff of the Family Center includes:

- Director
- Coordinator
- Nurse
- Researcher
- Case Aide
- Social Work Supervisor
- 4 Social Workers
- Six Lay Therapists
- Four Houseparents
- Secretary
- Volunteers
- Consulting Pediatrician, Psychologist, and Psychiatrist

PROJECT GOALS

To coordinate a multi-disciplinary approach in Adams County for the prevention, detection and treatment of child abuse.

To improve client functioning by providing responsive intake and treatment.

To demonstrate the role of a nurse as an important part of a child abuse team.

To determine the most effective treatment, within the context of a local department of social services, for abused children and their families.

To heighten community awareness about the dynamics and treatment of child abuse with emphasis on the need to report.

To increase the knowledge and involvement of school personnel in the child abuse services system.

To provide continuing child abuse coordination, referral and treatment services in Adams County after the federal funds have been withdrawn.

To develop a child abuse program model which will be applicable to other social service departments in the state and around the country.

PROGRAM COMPONENTS

Public Awareness and Community Education
School Referral Program
Family Center Advisory Board
Multidisciplinary Review Team
Crisis Response Intake Services
Medical Evaluation and Treatment
Twenty-four Hour Crisis Nursery
Therapeutic Foster Care and Day Care Programs
Lay Therapy Program
Specialized Treatment Programs for Children
    This includes individual and group counseling, structured play activity programs, behavior modification and theraplay programs.
Specialized Treatment Programs for Parents
    This includes individual and group counseling, educational preventive programs, self-help group counseling, couples counseling, and family counseling.
Training Programs for Foster and Day Care Parents
Volunteer Support Program

(A more detailed description of these components is available on request.)

PROGRAM EVALUATION

The Project Researcher and a consulting research psychologist are preparing a comprehensive analysis of each component. This information will be included in a manual which will be made available at the end of the project.

DISSEMINATION OF INFORMATION

A procedures manual describing how the Family Center Program can be duplicated will be prepared at the end of the project and made available on request. It is hoped that those efforts proven most effective will be continued as a part of the Adams County Department of Social Services' on-going program for parents and children in cases involving child abuse.

SOME DYNAMICS OF CHILD ABUSE

There are some behavioral and attitudinal traits of parents and children which are indicative of possible child battering. Some of these traits may be present without the occurrence of battering. When there is actual battering, however, many of these traits are almost always present.

Things to look for should you have the occasion to talk with parents or observe the interaction between parent and child:

1. Frequently, the parent has a distorted view of the child. The parent may describe the child as trying to hurt or anger him or may say the child does not love him. He may see the child as basically bad, deserving severe punishment. The parent may sound paranoid about the child, indicate feelings that the child is persecuting him and often projects his feelings onto the child.

2. Frequently, the parent's expectations of the child's behavior are not appropriate to the child's age. A mother may expect adult behavior from her child.

3. There may be a lack of warmth in the relationship between parent and child. Mother or father may not perceive and relate to the child's needs. The child may not behave as if he expects his needs to be met.

4. The parent wants the child to meet his needs. He wants to be loved, given to by the child as if the parent were the child and the child were the parent. This theme of role reversal seems to come through in many of the symtoms as it does in "a", "b" and "c" above.

5. There is almost always a history of battering in the background of one of the parents. The parent may feel beating kept him in line and is the right way to discipline children.

6. The parent may have high expectations of himself and the child. This may lead to the parent administering severe punishment for minimal behavior infractions. The parent's high expectations of himself has been internalized as a result of severe treatment and criticism of his parents when he was a child. This results in the parents usually reacting on a black is black and white is white basis with no recognition of gray areas. The parent may be critical of the child regardless of efforts made to please the parent. The parent seldom mentions any good quality in the child.

7. The parent may rationalize his treatment of the child, claiming it is necessary to prevent any sign of evil behavior from developing.

8. The parent may express a fear that he or she will hurt the child. They may describe an impulse to hurt or kill the child or may simply say she does not like the child. This sort of revelation would probably be rare without a strong relationship and deep trust being present. However, if it does occur, the parent is really asking for help and is at a critical turning point.

9. Frequently, the battering family is isolated in the community. There are no friends or social activities.

Some symptoms of abuse and neglect to look for should your contact be limited to just the child:

1. Obvious battering - the child or children will have bruises, sometimes showing the form of fingers or a hand, often a belt or belt buckle. There may be welts, lacerations, old scars, burns, etc.

2. They usually show little expectation of being comforted when in distress.

3. They may be wary of physical contact.

4. They may show apprehension when other children cry and when adults approach children who are crying.

5. They may frequently ask in words and through their actions what will happen next.

6. They may seem to be constantly in search of food, favors, or services.

Because there is some differentiation in the types of problems and referrals at the different school levels, Bob Yost from Child Welfare itemized the following symptoms to look for at the various levels:

Elementary Schools

*Obvious physical signs of alleged abuse. Black-blue marks, suspicious, unexplained bruises and scratches.

*Withdrawn in class

*Child is fearful of adults

*Poor peer relationships

*No adult supervision before or after school hours

*Child is sent to school long before classes begin

*Parents make no provision for child's lunch

*Poor hygiene habits

*Inadequate clothing

*Flimsy or no excuse for repeated absences from school

*Aggressive acting out behavior

*Poor home environment

Junior High Schools

*Physical evidence suggesting abuse

*Excessive absences, truancy, tardiness

*Poor home environment

*Poor parent/child relationship

*Lack of adult guidance and supervision

*Unable to conform with school regulations and policies

*Cannot compete academically in regular classroom

*Runaways

*Drugs (occasionally)

*Exploitation by parents: assuming too much responsibility at home

*Super strict parental discipline

*Sexual molestation charges

*Sexual promiscuity

Senior High Schools

At this level, the problems become appreciably more diffuse and complicated to diagnose. The child is more sophisticated and quite adept in manipulating the system to meet their own needs, and often times are the primary cause of a problem.

*Runaways
*Fear of "beatings" by parents. Refuse to go home
*Lack of communication with parents
*Truancy
*Lack of freedom and choice of friends
*Sexual acting out
*Exploitation of child
*Unrealistic discipline
*Poor school performance
*Poor home environment
*Emotionally unstable
*Other problems associated with emancipation needs

(Re-print - September 1974)

SUMMARY

It is hard to believe that such abuse happens in our so-called "enlightened age," and in a society which is essentially child-centered. As we have seen, work is being done on this problem, but there is much to be done as many people do not recognize child abuse as a major problem for consideration.

All classroom teachers, administrators, and counselors at some time or another will come into contact with an abused child. It is the responsibility of these educators to become involved until we reach a point where misuse of young children is no longer an everyday occurrence.

The laws are not clear as to what an abused child is. Therefore, educators need to learn from professionals in medicine, law, and the behavioral sciences what should and should not be done as well as what can and cannot be done.

It is necessary for educators not only to be sensitive to the needs of crippled, meek, fearful, lonesome, and aggressive children, but also to be able to identify and relate to the battered child. This child in particular needs someone to make him feel that he belongs, that he is wanted, that someone cares. He is a child in desperate need.

One of the tragedies of the battered child is that he has often developed characteristics that make him difficult; he is a child who has come to stimulate antipathy in the ones whose help he most needs: who is seemingly unresponsive or antagonistic to friendly and concerned outreach.

It is often said that a child is never so unlovable as when he most needs loving. This is so frequently true of the battered child that the classroom teacher who still reaches through to discern his need, his concealed cries for help, and who thus can begin the long process of his rescue and rehabilitation, meets a great challenge and must call on the sensitivity and empathy that characterize a remarkable and dedicated person. Of such people, there are more than we realize.

(Re-Print September 1974)

IDENTIFYING THE BATTERED OR MOLESTED CHILD

Physical Factors

1. Marks and Bruises on the Body: Some are visible, but some may be hidden from view. This is why a nurse's check is so important. Sometimes these marks and bruises may be hard to identify-especially if they are made by teeth or unusual instruments. It is particularly meaningful to note when these marks could not possibly be made by or incurred in the situation the child reports; i.e., bite marks on back due to "falling off a bike," whip marks on legs due to "falling while jumping rope," black eyes due to getting in a "fight with my cat," patches of hair missing due to "washing my hair too hard."

   A young child was seen in a nursery school to have odd marks, like bites, all over his back. When the mother was questioned she said they were indeed bites and that the child got them at the nursery school. The mother had not previously reported this to the nursery school, and the nursery school reported the situation to the Juvenile Probation Department and denied the charges. The mother then changed her story and said that they might not be bites, and she didn't know what they were. Police pictures were taken of the marks, and these pictures were shown to a group of five dentists who all stated that they were indeed the bite marks of a human adult.

2. Serious Injuries such as Broken Bones: Although these are most dramatically evidenced in very young children, an older battered child may often come up with a series of broken arms, fingers, head injuries, etc., or a variety of burns, ranging from minor to fatal, but consistently viewable.

3. Distended Stomach: Many battered children are not fed properly and appear to be malnourished. The parents often give excuses such as "he's a finicky eater," "he has a vitamin deficiency," or the "doctor doesn't know what's wrong with her." The truth of the matter is that these children are not fed at home or are fed only on scraps. They often do not come to school with lunch and steal food from other children, or they steal candy which they share to gain friends.

   Santa Clara County had a tragic and classic example of this in a fourteen-year-old girl who physically looked about seven, had not attained puberty, and who had been physically mistreated most of her life. She was also being starved to death.

   A lack of medical care for injuries can also be a significant factor and should be noted. Many parents will report that their child has "brain damage" and this, in fact, may be true. A neurological report on the child should be requested whenever possible. It has been found that many children do sustain minimal or severe brain damage through beatings or may be permanently damaged from incidents inflicted in early childhood.

4. Appearance of Mental Retardation: Battered and molested children often appear retarded, especially if the maltreatment has gone undetected for a prolonged period of time. This is often an excuse their parents give to questioning people in order to shift the blame away from themselves. Many of these children mature mentally and physically to a dramatic degree when removed from the family home.

5. Dirty Appearance: These children are often hygienically uncared for and are forced to wear cast-off clothing. The parents may report that they are clean when they leave for school and "just get dirty on the way." They may also say that the child has "torn up all the good clothes I just got her", implying that the child is mentally retarded or disturbed. It is especially important to note when one child is treated differently from the other children in the family-in the type of clothing, lunches, number of injuries or body cleanliness. Very often only one child in the family is singled out for cruel treatment, and this situation of scapegoating is also something that should be documented.

6. Cleanliness of the Home: Battered and molested children do not necessarily come from poor or lower income houses or families. It is just more difficult to detect and document those cases from middle and upper class families because the parents are usually more skillful in their deceit and have more sources available to cover up their pathology. It is not uncommon, however, to find a very clean, tidy lower income home with many children, all well cared for, that also houses one battered and neglected child.

EMOTIONAL FACTORS:

1. Regressive Behavior: Battered and/or molested children usually show signs of regressive behavior. They may become very childish, cry a lot, such their thumbs or withdraw into fantasy worlds. An abrupt change in a child's behavior should be documented and investigated. Sometimes these children give the impression of being mentally retarded when, in fact, they are not. The degree of emotional disturbance may be proportionate to the length of severity of trauma. Diagnosis is difficult if the child brings this behavior pattern with him when entering a new school. However, close observation will reveal deterioration as the child moves from grade to grade. School psychological services should be requested.

2. Acting Out Aggressive Behavior: Battered and molested children often act out their anger and hostility on others. They may become involved in delinquencies, i.e., petty thefts or trinkets which they give to other children to form friendships. Often they will steal food and monty in order to survive.

   The sexually molested girl may become sexually promiscuous, and her behavior may become the talk of, not only the school, but the whole neighborhood. Often a molested girl will confide in a special girlfriend or a favority woman teacher. These confidences may not take the direct form of information about being molested, but may involve such statements as "I'm afraid to go home tonight," "I want you to help me go live with my aunt in Stockton," etc. A wise and interested teacher can build up trust in a child and be standing by when the child holds out a desperate hand.

3. Poor Peer Relationships or Inability to Make Friends: Often these children do not have social skills or are too emotionally disturbed to form peer relationships. These relationships are usually frowned upon or forbidden by parents. The parents have a vested interest in keeping them emotionally isolated. The children have such a bad self-image that they cannot believe another human being could be interested in them in any way. Their built in "bad me" concept overshadows their whole existence.

Parents often move or try to move these children from school to school or environment to environment. An example of this was seen in the case of the previously mentioned fourteen-year-old girl who appeared to be age sever. Her mother withdrew her from school, stating she was going to live with relatives out of the county. Unfortunately, the school did not make contact with the "new" school, and the child was being kept at home and being mistreated. There were siblings attending school in the same district who could have provided this information, had they been asked.

4. Deep-seated Patholigical Impact: The victims of battering and/or child molestation often develop deep-seated psychiatric problems which have an impact on their whole future development. Evidence shows that the majority of men in prison who are classified as psychopathic or sociopathis personalities were beaten children. They have little feeling for others or guilt about their misconduct. The molested girl often becomes a prostitute. She finds it difficult to relate to men on any meaningful level and often fails to protect her own children from the same victimization.

The home life of these victims as adults is usually very unsatisfactory, and their pathology is passed on to their children...then to their children's children. Victims of molest are plagued with feeling of insecurity, guilt, bad self-image, depression and sexual problems. The victims of battering are filled with feelings of fear, hate, aggression, and an inability to empathize. The molested and battered child almost always needs psychiatric treatment if he is to make any kind of a positive psychological adjustment to life.

SELF-ESTEEM QUESTIONNAIRE

APPENDIX IV

NAME ______ NUMBER ______ LOCATION ______

IDENTIFICATION NUMBER		0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9
		0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9
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LOCATION NUMBER		0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9		0 1 2 3 4 5 6 7 8 9
MISCELLANEOUS CODES		SEX M F	M1	0 1 2 3 4 5 6 7 8 9	M2	0 1 2 3 4 5 6 7 8 9
	M3	0 1 2 3 4 5 6 7 8 9	M4	0 1 2 3 4 5 6 7 8 9	M5	0 1 2 3 4 5 6 7 8 9

NO. 1013

Use only a #2 pencil to mark your responses.

Mark only one response for each question.

Erase completely any response you wish to change.

Answer choices are: 1 = Not at all
2 = Only a little
3 = Depends or Not Sure
4 = Pretty much
5 = Yes, very much

		1	2	3	4	5
1.	I feel sure of myself.	☐	☐	☐	☐	☐
2.	Most of my friends accept me as much as they accept other people.	☐	☐	☐	☐	☐
3.	Does the situation described in number 2 upset you?	☐	☐	☐	☐	☐
4.	Most people who are important to me, who know me, think I do most things well.	☐	☐	☐	☐	☐
5.	Does the situation described in number 4 upset you?	☐	☐	☐	☐	☐
6.	Most persons my own age seem to be able to do things better than I.	☐	☐	☐	☐	☐
7.	Does the situation described in number 6 upset you?	☐	☐	☐	☐	☐
8.	I'm usually a lot of fun to be with.	☐	☐	☐	☐	☐
9.	Does the situation described in number 8 upset you?	☐	☐	☐	☐	☐
10.	Most persons who I want to do things with really want me to do things with them.	☐	☐	☐	☐	☐
11.	Does the situation described in number 10 upset you?	☐	☐	☐	☐	☐
12.	I'm satisfied with the way I handle most situations.	☐	☐	☐	☐	☐
13.	I'm popular with most people.	☐	☐	☐	☐	☐
14.	Does the situation described in number 13 upset you?	☐	☐	☐	☐	☐
15.	Most people my own age seem to be able to do things easier than I.	☐	☐	☐	☐	☐
16.	Does the situation described in number 15 upset you?	☐	☐	☐	☐	☐
17.	Other people who are important to me really accept me.	☐	☐	☐	☐	☐
18.	Does the situation described in number 17 upset you?	☐	☐	☐	☐	☐
19.	Most people my own age are more satisfied with themselves than I am with myself.	☐	☐	☐	☐	☐
20.	Does the situation described in number 19 upset you?	☐	☐	☐	☐	☐
21.	How self-confident do you usually feel?	☐	☐	☐	☐	☐

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Form SEQ-3

SELF-ESTEEM QUESTIONNAIRE
FORM SEQ-3

The following items have been selected because we think they may provide an estimate of your feelings of self-esteem. By self-esteem we mean how you feel about yourself. If you have high self-esteem, you would probably feel very positively about yourself. That is, you would probably think that the way you perform or get along in most situations is satisfactory and that, in general, other people really like and accept you. If, on the other hand, you have low self-esteem, this would probably mean that you thought that you did not get along very well in most situations. You would probably feel that you seldom did as good a job as others expected you to do. And you might think that other people felt that you could not do things satisfactorily most of the time, and that they did not really think too highly of you as a person.

There are five possible responses for each question, such that 1 – Not at all; 2 – Only a little; 3 – Depends or Not Sure; 4 – Pretty much; and 5 – Yes, very much.

For example, look at the statement below;

1. I feel sure of myself. 1 2 3 4 5 ▯ ▯ ▯ ▯ ▯

If you feel that you generally are very sure of yourself, then you would completely darken in the vertical space marked with a number 5, opposite question #1: 1 2 3 4 5 ▯ ▯ ▯ ▯ ▮

If you feel that sometimes you are sure of yourself and other times you are not, in other words, it depends upon where you are or what you are doing, then you would completely fill in the vertical space marked with a number 3, opposite question #1: 1 2 3 4 5 ▯ ▯ ▮ ▯ ▯

There are a number of statements followed by the question, "Does the situation described in number__ upset you?" These questions always refer back to the previous statement and are included in order to provide more complete information about how you really feel about these situations.

Please do not respond to any statement you do not understand, for we will not know how to interpret your response. If you would care to write any comments about such items or if you would like to add some comments about yourself which would increase our understanding of you, please feel free to write them on the bottom of this page.

There are no right or wrong answers to these items. Rather, your response simply indicates how you feel about yourself. Remember, your response to any question should indicate how you usually feel – not just an occasional type of thing.

Mark only one response for each question. More than one response will be treated as no response at all. Use only a #2 pencil to mark your answers. Please erase completely any response you wish to change.

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TEST ANALYSIS AND DEVELOPMENT CORPORATION
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APPENDIX V

FAMILY LEARNING CENTER
MARITAL ADJUSTMENT QUESTIONNAIRE

Name ____________ Age ____________ Date ____________

The marital adjustment questionnaire is a means of opening communications between husband and wife around areas of agreement or disagreement in their marriage. The questions must be answered honestly, and your response to the questionnaire should not be discussed with your spouse until both of you have completed filling it out. If you feel you cannot honestly answer a particular question, please leave it blank.

Please use the following code when completing the questions:

1 = YES, ALL OF THE TIME
2 = SOMEWHAT FREQUENTLY
3 = SOMEWHAT INFREQUENTLY
4 = NO, NEVER

1. Do you feel satisfied with the amount of leisure time you are spending with your spouse? ______
2. Do you remain unaffected by something that greatly affects your spouse? ______
3. Does your spouse refuse you when you initiate sexual intercourse? ______
4. Are you aware of your spouse's mood? ______
5. Is your spouse aware of your mood? ______
6. Do you and your spouse define what each is responsible for around the house? ______
7. Does your spouse follow through with those responsibilities? ______
8. Do you reveal personal or embarrassing things about yourself to your spouse? ______
9. Does your spouse understand when you reveal these things? ______
10. Do you talk about how your day has been with your spouse? ______
11. Does your spouse talk about how his/her day has been? ______
12. Do you express positive feelings toward your spouse? ______
13. Does your spouse express positive feeling toward you? ______
14. Do you want to spend more time with your friends than with your spouse? ______
15. Does your spouse want to spend more time with his (her) friends than with you? ______
16. Do you and your spouse agree on how to spend money? ______

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17. Do you count on your spouse for comfort when you need it? _____

18. Do you feel satisfied with your sex life? _____

19. Does your spouse count on you for comfort when he/she needs it? _____

20. Do you and your spouse let each other know when you are angry? _____

21. Do you and your spouse have a good time together? _____

22. Do you get involved with other men or women to the point where they are more important to you than your spouse is? _____

23. Do you believe that your spouse is a decent person, worthy of respect? _____

24. Do you prefer the company of others to your spouse's company? _____

25. Do you feel close to your spouse? _____

26. Do you and your spouse have nothing to say to each other? _____

27. Do you think that it would not be worth the effort to try and stay together if things were going badly between you and your spouse? _____

28. Do you feel unsure that your spouse would stay with you if things were going badly? _____

29. Do you generally believe your spouse's explanation of where he (she) has been? _____

30. Do you feel that your spouse is a basically good person? _____

31. Do you take your spouse's opinion into consideration when you have a decision to make (such as regarding your job or parents)? _____

32. Do you and your spouse enjoy the same activities together? _____

33. Do you believe your spouse is a good husband/wife? _____

34. Do you believe your spouse is a good mother/father? _____

35. Do you believe someone else would make you happier than your spouse? _____

36. Do you feel you know how your spouse will respond to your suggestions? _____

37. Do you believe that your spouse would be able to take care of the house and children if you left for a short time (overnight or for a few days)? _____

38. Do you believe your spouse would be able to take good care of himself/herself if you left for a short time (overnight or for a few days)? _____

39. Do you feel alone in your own house when your spouse is there? _____

40. Do you understand something your spouse says when others present do not understand? _____

41. Are you very often unpleasant or disagreeable to be around? _____

42. Is your spouse very often unpleasant or disagreeable to be around? _____

43. Do you feel your children, friends, parents or job is more important to you than your spouse? ____

44. Do you and your spouse lead separate lives? ____

45. Is your spouse helpful when you really need him/her? ____

BELOW ARE QUESTIONS CONCERNING YOUR EXPECTATION FOR GOOD AND BAD MARRIAGES

HOW OFTEN DO YOU THINK THE FOLLOWING WOULD OCCUR IN A REALLY GOOD MARIAGE?

47. The couple is open and honest with each other. ____

48. The partners feel close and loving toward each other. ____

49. The partners have the same interests. ____

50. Each spouse thinks for the other before himself. ____

51. The couple does things together in their leisure time. ____

52. The partners are there for each other when needed. ____

53. The partners share their intimate thoughts and private possessions. ____

WHAT IS THE MOST OFTEN THAT THE FOLLOWING MIGHT OCCUR AND HAVE A MARRIAGE STILL BE A GOOD ONE?

54. The partners feel angry at each other. ____

55. Either partner finds someone else attractive. ____

56. The couple disagrees over something. ____

57. A partner wants to be away from his spouse for a short time. ____

58. The partners would prefer to spend time with someone other than their spouses. ____

59. A partner is involved in activities other than work which do not include the other partner. ____

60. A partner does not tell his (her) spouse what his thoughts are. ____

HOW SATISFIED ARE YOU WITH YOUR MARRIAGE? ________

9 = Completely satisfied
8 = Very satisfied
7 = Fairly satisfied
6 = Somewhat satisfied
5 - Neither satisfied nor unsatisfied
4 = Somewhat unsatisfied
3 = Fairly unsatisfied
2 = Very unsatisfied
1 = Completely unsatisfied

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CURRICULUM FOR CHILD GROWTH AND DEVELOPMENT CLASSES

Monthly Growth and Development
- #1 New born
- #2 One Month Old
- #3 Two Month Old
- #4 Three Month Old
- #5 Four Month Old
- #6 Five Month Old
- #7 Six Month Old
- #8 Seven to Nine Month Old
- #9 Ten to Twelve Month Old
- #10 Thirteen to Sixteen Month Old
- #11 Eighteen Month Old
- #12 Two Year Old

Feeding
- Breast Feeding
- Formula Feeding
- Beginning Solids

Crying

Discipline

Diaper Rashes

Immunizations

Safety

Safety Car Seats

Sibling Rivalry

Toilet Training

Thumbsucking and Pacifiers

Play

Common Cold

Common Medications

Common Childhood Problems

8 Stages of Man - Erickson's Theory

#1 NEWBORN

DEVELOPMENT:

1) Your baby is a new person--unique and different from you, his father, his sisters and his brothers. Physically your newborn baby is a completely formed, perfect, tiny human being who is now equipped to live somewhat independently from you. He no longer needs your blood supply to feed him or your warmth to warm him. But he still needs much help in his adjustment to the outside world.

    a) His measurements will probably be between 18 - 21 inches in length and 6 - 9 lbs. in weight, and he will lose several ounces during the first week.

#2 ONE MONTH OLD

DEVELOPMENT:

1) Physically your baby will change a good deal within the first four to five weeks.

    a) He will gain between 1½ to 2 pounds in weight.

    b) His skin will be prettier, begin to look pink and smooth and not so large on his frame.

    c) His head will continue to be flat and funny shaped.

    d) His eyes will no longer be puffy and red. He will be keeping them open for longer times and looking at you.

    e) His navel and circumcision will be completely healed.

    f) When lying on his stomach, he will be able to lift his head off the bed.

#3 TWO MONTH OLD

DEVELOPMENT:

1) Physically, by two months your baby is beginning to look like the magazine pictures of newborns. He is filling out and looking a little chubby. His skin is pink, smooth and soft, and his eyes are settling on a color.

    a) He is still gaining weight, and his slight plumpness and lovely skin come from getting enough fluids to fill out his tissues.

    b) While he will still cross his eyes or let one eye roll to the outer socket area, he can for short periods of time focus both eyes on one object. He will gaze at your face for long moments. If a bright toy is carried past his face, he will follow it; sometimes to 180°.

#4 THREE MONTH OLD

DEVELOPMENT:

1) Physically the three month old is getting cuter all the time as he continues to fill out and get rounder.

    a) He will continue to gain weight by 1 - 2 pounds a month.

    b) With the possible exceptions of diaper rash, prickly heat or cradle cap, his skin is soft, smooth, pink.

    c) His eyes still wander in different directions, but he focuses for longer periods of times.

    d) The saliva glands in his mouth begin producing saliva. He doesn't know how to swallow this, so he begins to drool.

    e) He may have discovered his fingers and frequently sticks them in his mouth and sucks for pleasure and contentment.

#5 FOUR MONTH OLD

DEVELOPMENT:

1) Physically he is round, firm and well-packed. He is not fat, but just well built and looking like the advertisement for babies.

    a) He may like movement - being bounced on a lap, held in a standing position on his own wobbly legs.

    b) He has tried rolling over and probably done it once or twice to his own surprise.

    c) If placed on his tummy he will rise up on his elbows for a better look at the world, or he may arch his back and move his arms and legs as if he is swimming. This becomes a type of play.

    d) He is now able to focus on some object in front of him and reach for it. If it is a big object he may be able to grasp it with a wide swoop of the arm and hand.

#6 FIVE MONTH OLD

DEVELOPMENT:

1) Physically the five mmnth is a bundle of activity and movement.

    a) His eyes focus most of the time except when he is tired.

    b) He can now coordinate his eyes, his fingers and his mouth for exploring his world, and when this fails he shows his frustration.

    c) He will sit erect with some support.

d) He reaches for everything he can see and puts everything he can reach in his mouth.

e) He will transfer a toy from one hand to the other.

2) The five month old is a very social being.

a) He babbles to himself or anyone who will listen. He soon discovers several consonants and vowels and finds that combinations of "Dadadada" or "Babababa" bring great rewards from the family.

b) His span of attention is longer. He may be content to play in his chair or propped up for 30 - 60 minutes with only occasional help from the family.

c) He may hold out his arms to his mother when he wants to be picked up.

#7 SIX MONTH OLD

DEVELOPMENT:

1) A good deal of control has been gained by the time a baby is six months old.

a) He can now hold his head in line when he is pulled to a sitting position; reach for objects, roll over, scoot around and sit up by himself.

b) His eyes almost never corss or wander as he focuses them on his surrounding world.

c) He likes activity and is in constant motion during most of the day and often even in sleep.

#8 SEVEN TO NINE MONTH OLD

DEVELOPMENT:

1) Physically these will be happy contented months of concentrated learning of motor activities.

a) Some babies scoot - backwards and forwards, others actually master the art of crawling. This gives them instant mobility, and they move with real speed.

b) He will work on moving around more quickly, more smoothly and and cover more territory. He may crawl, scoot or just roll over and over, but he will learn to cover a lot of ground in a hurry.

#9 TEN TO TWELVE MONTH OLD

DEVELOPMENT

1) Physically the last two months of the first year are used to polish up some of the activities he tried earlier but didn't do very well.

a) He is very good at crawling or scooting around, soon discovers he can walk holding on to the furniture.

b) He may try letting go and just standing and then taking the first shakey steps, or he may wait until after his birthday.

c) By this time some babies begin to perceive heights and will test for distance (like backing off the sofa to see if his feet will touch the ground, and, if not, scrambling back up the sofa) while the others are in such a hurry they don't bother.

#10 THIRTEEN TO SIXTEEN MONTH OLD

DEVELOPMENT:

1) Physically the baby will not be changing as much as he did earlier.

   a) His weight tends to become more stable. He doesn't gain as much each month.

   b) He works on walking more smoothly and with more balance.

#11 EIGHTEEN MONTH OLD

DEVELOPMENT:

1) Physically the toddler changes more slowly and physical growth is less noticeable.

   a) Weight and height gains may come in spurts and show up only over a period of months.

   b) The toddler's walk is smoother and less of a waddle.

   c) He can throw a ball overhand 4 to 5 feet.

#12 TWO YEAR OLD

DEVELOPMENT:

1) Physically

   a) He may gain as little as 5 lbs during the year. His growth has slowed considerably.

   b) He learns to walk sideways and backwards.

   c) His running continues to become smoother and now he can stop and start more efficiently.

APPENDIX VII

Lay Therapy Program Questionnaire

In order to assess how the Lay Therapy Program is viewed by the protective service workers who have used this service, I would appreciate your completing one questionnaire for each of your cases that has been assigned a lay therapist.

1. Put in order of priority the reason(s) this case was originally referred to the Lay Therapy Program.

___ To reduce parent's isolation.
___ To increase parent's self-esteem.
___ To increase parent's self-reliance.
___ To provide parent assistance with following through on individual goals.
___ To provide parent assistance in changing patterns of parent/child interaction.
___ To provide parent a model for good parenting behavior.
___ To provide parent with education on child rearing practices.
___ Other - please explain________

____
____
____
____

2. If your reasons for maintaining lay therapy involvement with this case have changed, put in order of priority your reasons for lay therapy involvement at this time.

___ To reduce parent's isolation.
___ To increase parent's self-esteem.
___ To increase parent's self-reliance.
___ To provide parent assistance with following through on individual goals.
___ To provide parent assistance in changing pattern of parent/child interaction.
___ To provide parent a model for good parenting behavior.
___ To provide parent with education on child rearing practices.
___ Other - please explain________

____
____
____
____

3. If goal of lay therapy involvement has changed over time, please note the reason for this:

___ Original goals reached
___ Original goals unrealistic
___ Family situation changed
___ Other - please explain____

____
____

4. If you feel this client has achieved one or more goals since the start of lay therapy, would you please mark on the scale below where you feel your client is at this point in time. If you feel your client has not progressed but, in fact, has lost ground, please mark on the minus side of this scale.

-10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8 9 10

-10	0	10
	Client at beginning of lay therapy	The point you see your client realistically attaining

5. Please mark on the scale below how responsible you feel the lay therapist was for the client's postive achievement or regression.

-10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8 9 10

-10	0	10
Lay therapist totally responsible for client's negative movement	Lay therapist not responsible for client's positive or negative movement	Lay therapist totally responsible for client's positive movement

6. In order to get a sense of how appropriately the lay therapist used his/her contacts with you, please mark one of the sections below:

___ Lay therapist contacted you appropriately when case situation needed your attention or you needed to be made aware of a particular movement in the case.

___ Lay therapist's contacts with you were not appropriate-they were excessive.

___ Lay therapist's contacts with you were not appropriate-they were too infrequent and did not inform you of case situations you felt should have been brought to your attention.

7. We would appreciate knowing any positive or negative comments your client may have made about the lay therapist's involvement with him/her.

General comments:

INTERVIEW QUESTIONS USED IN SCREENING OF DAY CARE PARENTS

1. What past experiences have you had in working with special needs children? With abused/potentially abused children?
2. Why are you interested in becoming a therapeutic day care parent?
3. What forms of discipline do you use?
4. How were you disciplined as a child?
5. What have your past educational experiences been?
6. How do you see them helping you to relate to special needs children?
7. How do you feel you would relate to natural parents?
8. What is your emotional "gut level" feeling toward parents who abuse their children?
9. How do you see the role of the Family Center social worker?
10. How does your family feel about you being a therapeutic day care parent?
11. Are you willing to become involved in our research program?
12. How do you think that an abused/potentially abused child's behavior would differ from a non-abused child?
13. What is your definition of abuse?
14. What do you see as your role with the abused/potentially abused child?
15. What do you see as your role with the natural parents?
16. What are you willing to accept for financial reimbursement?
17. What other activities are you involved in beside being a day care parent?

OUTLINE FOR REFERRAL TO THERAPEUTIC DAY CARE HOME

I. The reason for the referral (Follow the criteria in the guidelines section).

II. An outline of the specific problems the child has.

III. An outline of the social worker's goals for this child.

IV. Has the child ever been in treatment before? If yes, with who, what type of treatment, and what was the outcome? If the child has been in treatment before, please enclose a release of information form.

V. Summary of background information on the family. Please focus on those dynamics that you feel may result in the child's specific behavior.

VI. What type of treatment have you been doing with the family? What are your goals for the family?

VII. What are the family's goals for themselves?

VIII. What are the parent's expectations of therapeutic day care for their child?

*Natural parents will need to provide the transportation to and from day care home.

TRAINING FOSTER AND DAY CARE PARENTS

I. Goal
   A. To provide training to foster and day care parents in the county to enable them to understand and deal with problems of abused children.
   B. To provide training to persons chosen as therapeutic day care and foster parents by the Family Center project.
   C. To provide training to foster care workers at the county department of social services, in anticipation that other training programs of a similar nature could be developed by that staff.

II. Objectives
   A. Make training applicable to the various needs expressed by the groups participating.
   B. Provide training in behavior management skills that could be used directly with problem children.
   C. Provide curriculum and training prototype to foster care staff at the county department of social services.

III. Implementation Tasks
   A. Survey foster flash day care parent training needs.
   B. Locate training resources.
   C. Develop an evaluation instrument to assess:
      1. Training effectiveness
      2. Attitude of participants toward training

IV. Process
   A. Training conducted by staff of a private residential treatment center for severely disturbed children.
   B. Focus of training on "parent effectiveness training" techniques.
   C. Individual child management problems of each of the participants were addressed.
   D. Training consisted of eight two and one-half hour sessions.
   E. Eighty-six percent of the participants rated the training as excellent, with a majority of the participants indicating they were currently using skills learned in class.

V. Strength of the Program
   A. Training provided to agency staff and foster flash day care parents in the same setting. This increased awareness and appreciation of problems on both sides.
   B. Training addressed specific problems that came up with abused children in placement.

VI. Outcome
   A. Training for foster parents in the county is now mandatory.
   B. Six training sessions a year are planned, and foster parents must attend two of their own choosing. These are self-contained three-hour workshops dealing with a variety of issues. Some of the training is conducted by the foster care staff of the department of social services, and some is contracted.
   C. The county department of social services is moving toward a therapeutic foster care program.

APPENDIX XI - A

FAMILY CENTER

SEMANTIC DIFFERENTIAL FORM

On the basis of your knowledge of this child please rate the child on the following adjectives using this scale Please place the child at the point on the dimension where you currently judge him/her to be. If you connot rate any dimension, indicate the reason (too young, no information, etc.).

Name of child________________ Age___ Worker______________ Placement______________

V=VERY M=MODERATELY S=SOMEWHAT N=NEITHER S=SOMEWHAT M=MODERATELY V=VERY

	V	M	S	N	S	M	V	
ACTIVE	()	()	()	()	()	()	()	LETHARGIC
ALERT	()	()	()	()	()	()	()	APATHETIC, STARES
EASILY FRUSTRATED	()	()	()	()	()	()	()	TOLERATES FRUSTRATION WELL
STUBBORN	()	()	()		()		()	COOPERATIVE
TEMPERAMENTAL	()	()	()	()	()	()	()	EASY GOING
DISTRACTIBLE	()	()	()	()	()	()	()	CAN CONCENTRATE
NEAT	()	()	()	()	()	()	()	MESSY
AGRESSIVE	()	()	()	()	()	()	()	PASSIVE
ADULT LIKE	()	()	()	()	()	()	()	INFANTILE
ANXIOUS, TENSE, NERVOUS	()	()	()	()	()	()	()	CALM, RELAXED
FRIENDLY	()	()	()	()	()	()	()	UNFRIENDLY
LIKEABLE	()	()	()	()	()	()	()	UNLIKEABLE
AVOIDS PHYSICAL CONTACT	()	()	()	()	()	()	()	SEEKS/ENJOYS PHYSICAL CONTACT
HAPPY	()	()	()	()	()	()	()	SAD
RELATES WELL TO ME	()	()	()	()	()	()	()	DOESN'T RELATE WELL TO ME
RELATES WELL TO PEERS	()	()	()	()	()	()	()	DOESN'T RELATE WELL TO PEERS
DEPENDENT, CLINGING	()	()	()	()	()	()	()	INDEPENDENT
FEARFUL	()	()	()	()	()	()	()	FEARLESS
EASILY DISCIPLINED	()	()	()	()	()	()	()	DIFFICULT TO DISCIPLINE
WARM, AFFECTIONATE	()	()	()	()	()	()	()	COLD, DISTANT
DEMANDS ATTENTION	()	()	()	()	()	()	()	NON DEMANDING
IMPATIENT	()	()	()	()	()	()	()	PATIENT
OPEN, TRUSTING	()	()	()	()	()	()	()	GUARDED, VIGILANT
PROUD OF SELF	()	()	()	()	()	()	()	CRITICIZES SELF
DEFIANT, DISOBEDIENT	()	()	()	()	()	()	()	OBEDIENT, OBEYS WELL
MANIPULATIVE	()	()	()	()	()	()	()	NON MANIPULATIVE
TRUSTING	()	()	()	()	()	()	()	DISTRUSTING
PRONE TO ANGER	()	()	()	()	()	()	()	NOT PRONE TO ANGER
BRIGHT	()	()	()	()	()	()	()	DULL
________________	()	()	()	()	()	()	()	____________________

FORM COMPLETED BY: ______________________________ DATE: __________

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FAMILY CENTER
CHILD'S ADJECTIVE CHECK-LIST

Childs name______________________ Age_____ Date__________

How often have you felt like each of the words below during the past week including today?

	Not at all	Sometimes; Not Very much Just A Bit:	Fairly Often; Most of the Time	Real Often; A lot; or Almost always
1. Happy				
2. Mad				
3. Full of Pep				
4. Sad				
5. Ready to Fight				
6. Proud of myself				
7. Wide awake				
8. Worn out				
9. Tired				
10. Scared				
11. Helpless				
12. Worthless				
13. Lonely				
14. Gloomy				
15. Like running away				
16. Upset				
17. Like not doing a thing				
18. Afraid				
19. Like I'm a problem or a Burden to my Folks				
20. Active				

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CHILD'S ADJECTIVE CHECK-LIST (cont)

2

	Not at all	Sometimes; Not very much; Just a bit	Fairly Often; Most of the Time	Real Often; A lot; or Almost always
21. Like Everything Will Be All Right				
22. Frightened				
23. Like Something Bad Might Happen To Me				
24. Nervous				
25. Hopeless				
26. Angry				
27. Likeable-Kids Like me				
28. Good				
29. Cheerful				
30. Bad				
31. Hopeful				
32. Loved				
33. Calm, Peaceful				
34. Sick				
35. Down in the Dumps				
36. Homesick				
37. Excited				
38. Important				

FAMILY CENTER
TELEPHONE SURVEY OF
CHILD'S BEHAVIOR

CHILD'S NAME ____________ AGE: ________ DATE: ____________

TIME OF DAY: ____________ INTERVIEWER: ____________

PLACEMENT: ____________ ____________

SOCIAL-WORKER ASSIGNED: ____________ LENGTH OF CALL ____________

Which of these behaviors occurred within the past 24-hours?

BEHAVIOR	OCCUR	NONOCCUR
1. Yelled at parent		
2. Yelled at peer or sibling		
3. Cried, whined or pouted		
4. Swore or cursed		
5. Hit parent		
6. Hit another child		
7. Intentionally threw or broke things, destroyed property, household furnishings		
8. Temper tantrum or strong outburst of anger		
9. Made threats, including third person threats such as "that monster is going to kill you"		
10. Argued with or talked back to adult		
11. Did not obey adult		
12. Shrieking or screaming		
13. Seemed "always on the go"		
14. Told lies		
15. Refused to interact with adults		
16. Avoided being touched		
17. Refused to play with other children		
18. Stared into space, seemed "in a world of his own"		
19. Hurt self intentionally --biting, head banging, etc.		

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BEHAVIOR	OCCUR	NONOCCUR
20. Talked to or rocked self		
21. Acted like a little adult or parent		
22. Overly helpful to adults		
23. Protected other siblings or peers		
24. Didn't accept help when offered		
25. Acted babyish for his age		
26. Wet self		
27. Soiled self		
28. Clung to parent or followed parent around		
29. Asked for help with something he could do himself		
30. Cried or got upset when parent left him/her		
31. Jealous over attention paid to others		
32. Sought out physical contact		
33. Hurt self accidently		
34. Sought out company of adults		
35. Sought out company of other children		
36. Acted in manipulative way with adults (Explain)		
37. Acted in manipulative wave with peers (Explain)		
38. Fearful of new situations or people		
39. Was timid, overly shy		
40. Complained of being sick --headache, stomachache, etc.		

BEHAVIOR	OCCUR	NONOCCUR
41. Stuttered		
42. Sexually inappropriate behavior		
43. Obeyed request by adult		
44. Engaged in one activity for longer than five minutes		
45. Laughed, giggled, sang, clapped hands, other happy behavior		
46. Put toys away		
47. Was sneaky		
48. Preoccupied with food		
49. Refused to eat		

ANY OTHER BEHAVIORS NOT MENTIONED ON THE ABOVE LIST:

FOR CRISIS NURSERY ONLY: NUMBER, AGES, AND SEX OF OTHER CHILDREN IN NURSERY.

FAMILY CENTER
RATING OF CHILD'S INTERACTION WITH PARENTS/FOSTER PARENTS

	NEVER	SELDOM	MODERATE FREQUENT	OFTEN	ALWAYS
1. Parent-child bond					
The child goes to the mother readily	N	S	MF	O	A
There is overt affection shown the child by the mother	N	S	MF	O	A
Mother appears interested in child's activities	N	S	MF	O	A
Comments on this varualbe:					
2. Fearfulness					
The child appears afraid of parent	N	S	MF	O	A
The child resists physical closeness	N	S	MF	O	A
Comments on this variable:					
3. Unresponsiveness					
The child ignores the parent	N	S	MF	O	A
The parent ignores the child	N	S	MF	O	A
Comments on this variable:					
4. Provocativeness					
Child deliberately provokes parent's anger	N	S	MF	O	A
Child persists when told to stop behavior	N	S	MF	O	A
Child appears to expect punishment	N	S	MF	O	A
Child teases or fights with sibling	N	S	MF	O	A
Sibling teases or fights with child	N	S	MF	O	A
Comments on this variable:					

5. Role reversal

The child showed "parenting" of parent	N	S	MF	O	A
The child was solicitous and over-anxious to please	N	S	MF	O	A
The child was successful in pleasing parent	N	S	MF	O	A

Comments on this variable:

6. Communication

The child successfully communicated feeling to parent	N	S	MF	O	A
The parent successfully communicated feeling to child	N	S	MF	O	A
Parent and child seemed emotionally close	N	S	MF	O	A

Comments on this variable:

7. Parents' behavior with respect to child's needs

Parents seemed to perceive what child needed when he behaved in certain ways	N	S	MF	O	A
Parents responded to child's needs by doing appropriate thing	N	S	MF	O	A
Parents set limits I considered appropriate	N	S	MF	O	A

Comments on this variable:

8. Expectations for child's behavior

Parent verbalized that child was in some ways disappointing him/her	N	S	MF	O	A
Parents' expectations of child seemed realistic	N	S	MF	O	A

Comments on this variable:

9. Discipline

I observed harsh punishment of child for minor infraction	N	S	MF	O	A
Corporal punishment occurred and was harsh or inappropriate for child's age	N	S	MF	O	A

Comments on this variable:

10. What changes have occurred since the last observation that this form fails utterly to measure?

Comments:

FAMILY CENTER

CLINICIAN'S RATING SCALE TO MEASURE TREATMENT OUTCOME

As a result of two and one half years clinical experience in working with abusing parents and their children, the Family Center staff has developed a rating scale to evaluate the progress and success of their treatment cases. An accompanying purpose of the scale was to compare scale scores with scores of the behavior forms that were collected on clients during their treatment. The intent was to determine what, if any, patterns emerges on the behavior forms for more successful and less successful cases.

The rating scale incorporates factors the clinicians view as treatment goals in working with abusing families. Adult client improvement, child improvement and parent/child/interaction are scored separately. Following is a list of the factors developed for each of these three areas; an explanation of how each factor is weighted for the final scoring process; and definitional questions for each factor. Each factor is scored on a scale from 1 to 4:

1 = miminal success toward achieving goal
2 = fair success toward achieving goal
3 = good success toward achieving goal
4 = optimal success toward achieving goal

A. ADULT CLIENT IMPROVEMENT.

Considered equally important as indicators of an adult client's improvement through treatment are: 1) Client's awareness of needs, 2) Client's self-control in terms of physical abuse, and 3) Client's development and use of support systems.

The eight factors on which adult client cases are rated fall into these three groups. Four of the factors (#1-4) deal with awareness of needs; one factor (#5) deals with self-control; and three factors (#6-8) deal with support systems. Each of the factors are weighted so that the three major areas of improvement will be scored equally. For example, the four factors dealing with "awareness of needs" have been given a wieght of 1, the one factor dealing with "self-control" has been given a weight of 4, and the three factors dealing with "support systems" have each been given a weight of 1 1/3.

1. Client has awareness of own needs. (Weight=1)

One of the most common character traits found in abusive parents is their lack of awareness of their own needs. As children, these adults were taught to attend to the needs of their parents with no recognition or realization of their own needs. This pattern becomes well established by adulthood. Therefore, the client's recognition of his/her own needs is seen as an important first step in the treatment process.

   a. Can client talk about areas of his/her life that cause frustration, i.e., spouse, children, work, isolation, problems with parents, etc.

   b. Can client address these areas with some degree of awareness in terms of what he/she wants or needs out of them?

2. Client has awareness of his/her own needs as separate from the child's needs. (Weight=1)

Because of the cycle discussed above, abusive parents have difficulty appropriately breaking the symbiotic relationship with their child and acknowledging having needs of their own. Therefore, they very often project their needs onto the child, or they merge with the child and his/her needs. Therefore, the separating out of needs is very important.

   a. When client feels the need to be alone, can he/she do this without rejecting the child?
   b. When client feels the need to be taken care of can he/she get this need met without smothering the child?
   c. Is the client able to maintain a separate emotional identity?

3. Client can identify child's needs. (Weight=1)

Numbers 1 through 3 are a progression in that only when the parent can separate out his/her needs from the child's needs, can he/she begin to identify the child's specific needs.

   a. Does parent recognize child's need to be independent?
   b. Does parent recognize child's need for nurturing?
   c. Does parent recognize the child's feelings, i.e., sadness, happiness, anger, frustration, etc.?

4. Client has ability to translate self-awareness into behavior change. (Weight=1)

Again, this factor is part of a progression. A client will be scored for awareness because that is progress. However, at the optimal end of the continuum is the ability to translate that awareness into a behavior change which involves actually meeting the needs of self or child.

   a. Has the client initiated any positive changes in the life important areas mentioned above (spouse, children, work, isolation, etc.,)?

5. Active abuser has impulse control/passive abuser has developed assertiveness in conflict situations. (Weight=4)

Frequently, abuse occurs because a parent becomes angry and loses control in administering discipline. If the active abuser has impulse control the abuse is less likely to occur. A passive abuser who has been the silent partner in an abuse situation is considered better able to protect the child if he/she is able to be assertive and prevent the abuse.

   a. Has physical abuse stopped?
   b. Has verbal or emotional abuse stopped?
   c. Can client separate himself/herself (either physically or by gaining a perspective) from situations that may cause loss of self-control.
   d. Is a passive client able to deal effectively with conflict situations?
   e. Can the passive client effectively protect his/her children?

6. Client makes good use of support systems. (Weight= 1 1/3)

A factor common to abusive parents is their isolation and lack of people and places to turn to for support. It is not the expectation that therapy would totally reverse this isolation, but rather that clients would be helped to know how and when to go for support when it is needed. It is also important to note that for optimal progress, a client has to reach beyond the therapist. Although reaching out to the therapist may be progress, it may also be or become a type of dependence, and learning to reach out in a variety of ways would be considered optimal. A greater variety of support systems is one indicator of the client's ability to continue problem solving after the treatment ends.

   a. Does client contact therapist when in need?
   b. Does client reach out to family or friends for support?
   c. Does client use any other supporting persons, groups, or agencies when in need?

7. Client initiates activities or relationships. (Relationships: Weight=1)
(Activities: Weight= 1/3)

This factor is divided into two categories with different point values. "Client initiates relationships" is given the higher value because clinicians view isolation from other people as a primary dynamic of abusive parents. Thus, initiating a relationship would be more important than initiating an activity which is the second category and has a lesser value.

   a. Has client made any new friends?
   b. Has client begun a new job, joined any new organizations, begun any new hobbies or learned a new skill?

8. Client can maintain an emotionally mature relationship. (Weight=1 1/3)

Many abuse situations occur because of the client's inability to establish or maintain a mature adult relationship. On a continuum from initiating a relationship would be the ability of a client to maintain a healthy one. This question addresses the issue of quality in a relationship.

a. Can client maintain relationships with spouse, parents and friends that are not hostile and dependent ones?
b. Can client maintain a separate emotional identity with his/her adult relationships?
c. Is there an increase in client's healthy communication with significant others?

B. CHILD IMPROVEMENT.

There are two factors which attempt to capture the child's improvement. These are the child's relatedness and the child's self-confidence and feelings of self-worth. The child relatedness factor is subdivided into five behaviors which are measured independently, and these are:

Child attempts to relate.
Child attempts to communicate feelings.
Child relates in a way which gives him positive reinforcement.
Child relates in a consistent, genuine, spontaneous, non-manipulative manner.
Child relates in an age appropriate fashion.

These five behaviors, plus the factor dealing with the child's self-confidence, are scored in relation to the child's progress with peers, parents, adults and therapist. Therefore, there is a multiple weighting system. Each of the five relatedness areas have a weight of 1 and the self-confidence factor has a weight of 5, so that progress in the relatedness factor and the self-confidence factor are given equal weights. In addition, peers and parents are given weights of 2 and adults and therapist weights of 1, since the clinicians view improvement in relatedness and self-confidence as more important with peers and parents than with adults and therapists.

1. Relatedness (Weight=5)

a) Does the child attempt to relate (Weight=1)

Does the child even care to relate, or is he/she withdrawn? Clinicians view any step a child might take to relate to an adult or peer as being a positive sign, even if the attempt to relate brings negative results.

1) Does child have any friends?
2) Does child make consistent and appropriate eye contact?
3) Is child outgoing and willing to interact?
4) Is child verbal?

b) Child attempts to communicate his/her feelings (Weight=1)

This is similar to the adult's awareness of his/her needs. As children these adults were taught to look out for and attend to the needs of their parents with little recognition of their own needs and feelings. Therefore, it is very important for abused children to attempt to communicate their feelings in a positive fashion. "Positive" is defined as communication in a growth producing manner and expressing a wide range of feelings.

1) Is child able to express his feelings verbally or through actions in an age appropriate manner?

c) Child relates in a way that gives him/her positive social reinforcement (Weight=1)

Abuse is a cycle and over time (depending on length of time abuse has been occuring and severity of abuse) these children learn to be provocative. Very often, the only attention they receive is for negative behaviors, so when they are in need of attention they act out. Therefore, it is very important that these children be helped to gain control over their behavior as a way of affecting the abuse cycle and learning to be better adjusted people.

1) Can child compromise?
2) Does child have control over behavior?
3) Does child have a sense of appropriate behavior?
4) Can child exist harmoniously within his social environment?

d) Child relates in a consistent, genuine, spontaneous, non-manipulative manner. (Weight=1)

1) Child is not promiscuous or phony in his relationships.

e) Child relates in an age appropriate, independent fashion (Weight=1)

Since a great many abused children learn to parent adults, it is very important to assess whether their communication is age appropriate or an effort to meet the needs of the adults around them.

1) Does child get satisfaction from doing things for himself?
2) Does child seek out growth producing experiences?
3) Is child avoiding role reversal behaviors?

2. Child has self-confidence and feelings of self-worth (Weight=5)

Abuse, itself, tends to make children internalize a bad self-image. These children also learn to meet the needs of adults around them and they see their own feelings and concerns as having little value. In their struggle to meet their parent's needs and high expectations, they often fail, which leads to feelings of inadequacy. In addition, their models are generally parents who themselves have low self-esteem. This all contributes to producing a poor self-image. Therefore, in working with these children, it is essential to help them develop good self-esteem.

  a. Does child project a positive self-image?
  b. Can child easily and appropriately adapt to new people and new situations?
  c. Does child talk about self in a positive fashion?

C. PARENT-CHILD INTERACTIONS.

Parent/child interactions is scored on seven factors. The first and most important being "physical abuse stopped/potential for abuse stopped." This factor is given a weight of 2 and each of the remaining six factors have a weight of 1.

1. Physical abuse/potential for abuse stopped (Weight=2)

This factor is considered most important in measuring parent/child interaction since preventing abuse protects the child and allows the parent/child interaction some potential to grow. The reduction of emotional abuse, also considered very important by the clinicians, is measured indirectly by factors two through seven below.

2. Parent listens to child (Weight=1)

(See discussion under three below)

  a. Can parent tolerate listening to child's explanation of things?
  b. Is parent able to foster a dialogue with child in an accepting, non-judgemental manner?

3. Parent reaches out to child in a positive way (Weight=1)

  a. Does parent initiate enjoyable activities with the child?
  b. Can parent set realistic limits for the child?
  c. Is parent consistent with the child?
  d. Parent is not resentful of having to spend time with his child.

Most of the parent/child interaction factors, such as two and three above and six and seven below, measure the parent's initiative. Although the clinicians feel it is also important for the child to be helped to initiate positive interactions with the parent, they see this as primarily the parent's responsibility. They do not feel it is possible for the child to break the unhealthy symbiotic relationship without the parent making the first move and continuing to provide an environment for healthy, positive interaction to grow.

4. Child reaches out to parent in a positive way (Weight=1)

This would indicate that there is not only a healthy distance in the relationship, but also that there is appropriate closeness so that the child feels he/she will be taken care of and helped in time of need.

a. Does child go to the parent for appropriate help?
b. Is child comfortable talking to the parent about feelings?

5. Parent and child reach out to each other in a mutually positive and nurturing fashion (Weight=1)

The optimal success in parent/child interaction is seen when there is mutuality and reciprocity in the positive interactions.

a. Is time parent spends with child pleasurable for parent and child?
b. Is the communication between parent and child clear with no mixed messages?

6. Parent/Child interaction relates to child's need (Weight=1) (See discussion under two and three above)

a. Parent reinforces child for being a child.
b. Are parent's expectations of child age appropriate?
c. Is child encouraged to play?
d. Is child encouraged to have friends?

7. Parent does not look to child for adult-like support (Weight=1) (See discussion under two and three above)

a. Parent does not expect child to be sensitive to his mood swings and upsets.

ADULT CLIENT IMPROVEMENT

Client's Name ____________________

Beginning Rating ______

End Rating ______

Social Worker ____________________

SUCCESS FACTOR	(WEIGHT)	SCALE SCORE	TOTAL SCORE (weight x scale score)
ADULT CLIENT IMPROVEMENT			
(1) Client has awareness of his own needs.	(1)		
(2) Client has awareness of his own needs as separate from child's needs.	(1)		
(3) Client has awareness of child's needs.	(1)		
(4) Client has ability to translate self-awareness into behavior change.	(1)		
(5) Client has impulse control/ or passive client has developed assertiveness.	(4)		
(6) Client makes good use of support systems.	(1 1/3)		
(7) Client initiates activities or relationships.	(1 1/3)		
a. Client initiates relationships.	(1)		
b. Client initiates activities.	(1/3)		
(8) Client can maintain an emotionally mature relationship	(1 1/3)		

CHILD IMPROVEMENT

Client's Name ____________ Beginning Rating ________

Social Worker ____________ End Rating ________

SUCCESS FACTOR	(WEIGHT)	SCALE SCORE				TOTAL SCORE (weight x scale score)			
CHILD IMPROVEMENT		Peers	Parents	Adults	Therapist	Peers	Parents	Adults	Therapis
(1) Social Interaction	(Weight)	(2)	(2)	(1)	(1)				
a. Child attempts to relate.									
b. Child attempts to communicate feelings.									
c. Child relates in a way which gives him positive social reinforcers.									
d. Child relates in a consistent, genuine, spontaneous, non-manipulative manner.									
e. Child relates in an age appropriate, independent fashion.									
(2) Child has sel-confidence and fellings of self-worth	(5)								

PARENT/CHILD INTERATIONS

Client's Name ____________ Beginning Rating ________

Social Worker ____________ End Rating ________

SUCCESS FACTOR PARENT/CHILD INTERACTION	(WEIGHT)	SCALE SCORE	TOTAL SCORE (weight x scale score)
(1) Physical abuse stopped/ potential abuse stopped.	(2)		
(2) Parent listens to child	(1)		
(3) Parent reaches out to child in a positive way	(1)		
(4) Child reaches out to parent in a positive way	(1)		
(5) Parent and child reach out to each other in a mutually positive and nuturing fashion.	(1)		
(6) Parents/child interaction relates to child's needs	(1)		
(7) Parent does not look to child for adult like support	(1)		

Instructions For Using The "Rating Scale for Behaviors and Reactions Observed During Cognitive Testing"

The scale is constructed so that scores for problems in the areas of relationship to examiner, self concept, frustration tolerance, concentration, attentional difficulties and impulse control can be obtained. Items are scored so that point totals can be obtained for each area which indicate the presence or absence of problems in that area. A separate score is calculated which indicates the degree to which each problem interferes with the child's performance on the test. These ratings reflect the judgment of the examiner about the effect of any behavior on the child's test performance. They are:

Severe Interference - Indicates that this behavior, reaction or problem was not only present, but had a serious and pervasive impact on the overall test performance of the child.

Moderate Interference - Indicates that a behavior, reaction or problem was present, and interfaced with performance on certain portions of the exam, or at certain times during the testing session.

Mild Interference - Indicates that a behavior, reaction or problem was present and affected the child's test performance only slightly and/or infrequently.

No Interference - Indicates that a behavior, reaction or problem was present, but did not seem to affect test performance (such a behavior as eagerness to please can sometimes work to a child's advantage during the test, and thus be present but not interfering). No interference is also used when a problem is absent, in which case the degree of interference will obviously be none.

I. Problems relating to examiner

(Circle presence or absence score indicating existence or non-existence of problems in this area observed during testing session). Degree of interference with child's test performance:

3 - No relationship formed and child will not comply with testing (this child appears unreachable).

2 - No relationship formed and child's performance less than optimal due to low motivation in absence of relationship.

2 - Relationship formed but problems with quality of relationship exist which interfere somewhat with performance.

1 - Relationship is formed and problems with quality exist which do not affect test scores negatively (for example, child whose need to please may be excessive but this works to his/her advantage).

0 - Adequate, appropriate relationship to examiner present.

Types of behaviors or responses to examiner:

1. Depressed, withdrawn (shows little interest in examiner, (appears sad; depressed effect).

2. Distrustful, defensive (sullen, wary).

3. Fearful, frightened (frightened, hesitant or anxious about relating).

4. Hostile, aggressive manner (including angry, hostile statements and testing limits or making overt demands).

5. Clinging, dependent attachment (affection seeking, indiscriminate attachment, superficial in nature. In extreme forms, it can be aversive to examiner).

6. Eager to please (tries to find out what examiner wants and does that. In extreme forms, energy is focused on pleasing examiner rather than on own test performance).

7. Overtly pleasant and cooperative, but covertly manipulative or resistant (or passive-agressive style).

8. Relates in superficially adult manner (tries to gain positive regard by imitating adult manner at expense of childhood needs and impulses).

9. Hypervigilant attention to examiner. The child watches the examiner closely, observing every move and expression. He/she may ask many questions such as, "What are you doing?"

II. Self Concept Problems Evident During Testing

1. If any problems were observed circle present, (1) if not, circle absent (0).

2. Estimate the overall degree of interference with test performance from self concept difficulties as severe, moderate, mild, or none.

Types of self concept problems observed:

A. Defensive styles - resisting admitting negative self image.

   1. Denial of problems - boastful style (insists is doing well when is not, says how "great" he/she is, bravado present).

   2. Angry, hostile response to failure (expresses disdain towards tests, schools, and seems to deny own failure be externalizing blame).

B. Acceptance of negative self image.

   1. Overly self critical (cannot satisfy expectations, so criticizes self even when does well, does not believe success possible).

   2. Child sets high goals for perfect performance (anything less than perfection is unacceptable to child and considered failure to him/her).

   3. Fear of failure on tasks (expresses concern over being able to do well. May frequently ask how he/she is doing, "Am I doing all right?"). Anxiety often present.

   4. Child self defeating, sets self up to fail (child who says "I can't," "I'm too stupid," "I never do things right." Seems to have given up on self and given up on trying).

III. Problems With Frustration Tolerance

The presence of a problem in this area should be scored on the basis of whether the child shows a performance decrement due to the frustrations inherent in the testing situation. If problems are present, how severely the lack of frustration tolerance affects test score should be indicated by the degree of interference scale.

Types of reactions:

1. Child withdraws from task ("I can't do it," etc.).

2. Child becomes angry at examiner when frustrated (projects blame to examiner; "You're a dummy," etc.).

3. Child expresses anger at test materials (throws things, breaks materials, pushes materials away, says, "This is a dumb test.").

4. Child exhibits regressive, infantile behavior (baby talk, whimpers, whines, asks for help constantly or says, "You do it.").

IV. Concentration and Attentional Difficulties

Overall rating based on whether child has problems concentrating and attending to tasks on test (present or absent), and how much this interferes with test performance.

Specific problems interfering with attention and concentration:

1. Difficulty sitting still (can range from hyperactivity to restlessness).

2. Distractible (attention drawn to external interference, other people, sounds outside room, other toys in room).

3. Distractible -attention drawn to internal or emotional preoccupation (talking about feelings about self, fears, home problems, things that happened that day, future concerns). Child may not talk much about them, but check for this if it seems that they are worried or preoccupied.

4. Preoccupation with examiner's reactions (attention so focused on relationship to examiner that attention to task suffers).

5. Preoccupied with getting emotional needs met. (May be the clinging dependent child. Some look for physical affection. Others may seek material gratification, wanting to keep test mtaerials as "presents" or "prizes." May try to sneak away materials).

V. Impulse Control Problems

Overall rating made about whether overcontrol, or impulsivity is present or absent and to what degree it interferes with test performance.

Types of problems in impulse control area:

A. Overcontrol problems - inhibitions

   1. Overcontrolled, inhibited response to test material (afraid to touch materials and interact with tests as if afraid punishment could occur, particularly on motor tasks such as striking xylophone or throwing bean bag).

   2. Verbal inhibition present (reluctant to communicate verbally, expressive difficulty, as if speaking is likely to be dangerous or punishable).

3. Overly polite response (relating in an adult-like manner, often saccharin, trying to stay safe and obtain positive regard by relating in imitation of adults. There is a denial of child-like needs and impulses).

B. Impulsivity, undercontrol

1. Failure to think before acting (child fails to pause and consider a response, or to scan material properly; just seems to give first solution that comes to mind).

2. Child has difficulty controlling his motor behavior and/or impulses of an angry, needy or fearful nature.

On the presence or absence scale, a score of 29 indicates the maximum presence of problems which could interfere, and a score of zero indicates all listed potential problems are absent.

All that can be said about how to interpret a score at this time on the severity scale is that a score of zero would indicate no behavior problem interference and a score of 72 would indicate maximum behavior interference.

Since the maximum score of 72 indicates the presence of serious interference in every area rated, it is likely that only a rare child will achieve that score. Thus, a significant amount of interference will not necessarily be close to the maximum score.

Furthermore, significant interference can be a result of moderate interference in several areas, or severe interference in one or two pervasive areas. Only the practical application of this instrument can determine what scores are significant and meaningful.

Rating Scale for Behaviors and Reactions Observed During Cognitive Testing

			Degree of Interference with test Performance			
	Pres.	Abs.	Sev.	Mod.	Mild	None
I. Overall Problems relating to examiner during testing session.	1	0	3	2	1	0
A. Quality of relationship to examiner						
1. Depressed, withdrawn	1	0	3	2	1	0
2. Distrustful, sullen, wary	1	0	3	2	1	0
3. Fearful, frightned	1	0	3	2	1	0
4. Hostile, aggressive	1	0	3	2	1	0
5. Clinging, dependent	1	0	3	2	1	0
6. Eager to please	1	0	3	2	1	0
7. Overtly cooperative, but covertly manipulative	1	0	3	2	1	0
8. Superficially adult-like style	1	0	3	2	1	0
9. Hypervigilant	1	0	3	2	1	0

			Degree of Interference with test Performance			
	Pres.	Abs.	Sev.	Mod.	Mild	None
II. Problems in self concept observed during testing	1	0	3	2	1	0
Types of self concept problems observed:						
A. Defensive styles - resisting negative	1	0				
1. Denial of problems with test or boasting when failing	1	0	3	2	1	0
2. Angry, hostile response to failure	1	0	3	2	1	0

			Degree of Interference			
	Pres.	Abs.	Ser.	Mod.	Mild	None
B. Styles indicating acceptance of negative self concept						
1. Highly critical of own performance	1	0	3	2	1	0
2. Sets perfectionistic goals for self	1	0	3	2	1	0
3. Fear of failure on tasks	1	0	3	2	1	0
4. Expectation of failure, self defeating	1	0	3	2	1	0
III. Inability to tolerate amount of frustration inherent in test situation	1	0	3	2	1	0
A. Types of responses to frustration						
1. Withdraws from task when frustrated	1	0	3	2	1	0
2. Angry at examiner when frustrated	1	0	3	2	1	0
3. Angry at test when frustrated	1	0	3	2	1	0
4. Regressive, infantile behavior when frustrated	1	0	3	2	1	0
IV. Concentration and attentional difficulties	1	0	3	2	1	0
A. Specific problems in this area						
1. Difficulty sitting still	1	0	3	2	1	0
2. Gets distracted by other external stimuli	1	0	3	2	1	0
3. Seems distracted by internal or emotional concerns	1	0	3	2	1	0
4. Preoccupied with examiner's reactions	1	0	3	2	1	0
5. Preoccupied with getting emotional/affectional needs met	1	0	3	2	1	0

	Pres.	Abs.	Degrees of Interference			
			Sev.	Mod.	Mild	None
V. Impulse Control Problems	1	0	3	2	1	0
Types of Control Problems observed:						
A. Overcontrolled						
1. Inhibited response to test material	1	0	3	2	1	0
2. Verbal inhibition, expressive problems	1	0	3	2	1	0
3. Overly polite, denying child-like impulses	1	0	3	2	1	0
B. Uncontrolled						
1. Failure to stop and think before making test responses	1	0	3	2	1	0
2. Inability to control behavior and/or impulses	1	0	3	2	1	0

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